Pelvic Pain Questionnaire

www.pelvicpain.org.au

Before your visit we ask that you answer the questions on this sheet. They help us understand your concerns better and allow us more time at your visit to discuss the issues most important to you.

For some of the questions we have asked you to tell us how bad your pain is on a scale from 0-10. A score of 0 would mean No pain at all, and 10 would be the worst pain you can imagine. Other questions ask you to circle the answer that describes your pain best. If your problems vary from month to month, think about how they might affect you on a typical month over the last 3 months.

You and your pain

1. Your age _____

3. How many days over an average month would you have pelvic pain or discomfort of any kind, even mild pain? (number 1-30)_____

4. How many days over an average month would you be entirely well with no pelvic discomfort at all? (number 1-30)_____
(Please note that the answer to Q 3 and Q 4 should add up to 30)

5. How much pain do you have today? Pain Score (0-10) _____

Your Medications

7. Are you currently using any of these hormonal medications?

Implanon	Yes / No	
Mirena IUCD	Yes / No	
Oral contraceptive pill	Yes / No	(name of pill) _____
Other	Yes / No	(name) _____
No, I don't use any hormonal preparations		

Your Periods

10. How old were you when your periods started? _____

11. Do you have period pain? Yes / No / Occasionally Pain Score (0-10)_____

If so,
How old were you when your periods became painful? _____

For how many days each month do you have period pain? _____

Where do you feel your period pain? (circle as many as apply)

Low abdomen at the front / Lower back
Left side lower abdomen / Right side lower abdomen
Front of the legs / Back of the legs / Foot / Anal area
Another place _____

Does the contraceptive pill help your period pain? (circle)

Yes, a lot / a little / not at all / I have never tried the pill /
My period pain started when I stopped taking the pill

Do period pain medications (ibuprofen, Ponstan, Naprogesic etc) help your period pain?

Yes, a lot / a little / not at all / I have never tried these medications

12. When was the first day of your last period? _____

13. How long between the first day of one period and first day of the next period? _____

14. How heavy is the bleeding? Light / Medium / Heavy / Variable

Stabbing pains in your abdomen

15. Do you have sudden or stabbing pains in the pelvis or abdomen?

Yes / No / Occasionally Pain Score (0-10) _____

If so,

How old were you when these pains started? _____

Where do you feel these pains? (circle as many as apply)

Low abdomen at the front / Lower back
Left side lower abdomen / Right side lower abdomen
Front of the legs / Back of the legs / Foot / Anal area
Another place _____

Do any exercises or movements make these pains worse?

Yes / No _____

Do any exercises or movements make these pains better?

Yes / No _____

Your Bowel

16. Do you have problems with your bowel? Yes / No / Occasionally

If so,
How old were you when your bowel problems started? _____

Do you have constipation? Yes / No / Sometimes / Only with periods

Do you have diarrhoea? Yes / No / Sometimes / Only with periods

Do you feel bloated? Yes / No / Sometimes / Only with periods

Do you have bowel pain? Yes / No / Sometimes / Only with periods

Your Diet

17. Are there foods that don't suit you? Yes / No

If so, which foods don't suit you?

Wheat	Yes / No
Dairy foods	Yes / No
Fatty foods	Yes / No
Other foods	_____
Food Allergies	_____

Your Bladder

18. How many times do you pass urine each day?

While awake? _____

At night, after going to sleep? _____

19. Do you have problems with your bladder? Yes / No / Occasionally / only with periods

If so, At what age did these bladder problems start? _____

When you need to pass urine, can you wait until later, or do you need to go straight away?

I can wait until later / I need to pass urine straight away

Do you have bladder pain? Yes / No / Only when I try to 'hold on'

Pain Score (0-10) ____

Do you have pain passing urine? Yes / No / Occasionally / Only with periods

Are there times when you find it difficult to start passing urine? Yes / No / Occasionally

How much fluid do you drink each day? _____

Headaches

20. Do you get headaches? Yes / No / Occasionally

If so,
At what age did your headaches start? _____

Do you get headaches at period time? Yes / No / Every period / Some periods
Pain Score (0-10) _____

Do you get bad headaches or migraines at other times? Yes / No / Occasionally
Pain Score (0-10) _____

Do you get milder background headaches at other times? Yes / No / Occasionally
Pain Score (0-10) _____

21. Have you ever been diagnosed with migraines? Yes / No

22. How many days a month do you have a headache, even a mild headache? _____

23. How many days a month are you completely free of headache (no headache at all)? _____
(Please note that the answers to questions 22 and 23 should add up to 30)

Your General Wellbeing

25. Do you have any of the following symptoms?

Unusual tiredness or fatigue?	Yes / No / only with periods
Poor sleep?	Yes / No / only with periods
Unusual sweating?	Yes / No / only with periods
Dizziness or feeling faint?	Yes / No / only with periods
Anxiety?	Yes / No / only with periods
Low mood?	Yes / No / only with periods
Nausea?	Yes / No / only with periods

Your Vulva (The Vulva is the skin between your legs near the opening of the vagina)

24. Do you have vulval pain? Yes / No Pain Score (0-10) _____

If so,
When would you get this pain? (circle as many as apply)

Anytime / with intercourse / using tampons / only with a vaginal infection or thrush

Your Sexual Wellbeing

Please note that questions 26 to 31 are optional and may not apply to all girls or women.

26. Are you currently or have you ever been in a sexual relationship?

Yes / No / I prefer not to answer this question

If so,
Do you feel pain or discomfort during sexual activity? Yes / No / Occasionally
Pain Score (0-10) _____

When do you get this pain? (please circle as many as apply)

With arousal / during intercourse / after intercourse / the day after intercourse

At what age did intercourse become painful? _____

Have you experienced distressing sexual events during your life, including sexual assault?

Yes / No / I prefer not to answer this question / I would like to discuss this during my appointment / I prefer *not* to discuss this during my appointment

Pregnancy and Contraception

27. Have you ever been pregnant? Yes / No

28. Do you have children?_____ How many?_____

29. Are you currently trying to become pregnant?_____

If not, what type of contraception are you using?_____

30. When was your last smear test? _____ Was it normal? _____

It is possible that we may wish to use this data anonymously in the future for research purposes. We will only do this with your consent. Please note that the sheet with your personal details would be removed from this record and you would not be identified in any way. (please tick a box)

Yes, I agree to this information being used anonymously for research □
No, I do not agree to this information being used anonymously for research □

Thank you very much for taking the time to complete this questionnaire