

Today's Date:

Chart Number (FOR OFFICE USE ONLY):

1. Contact information

<p>Legal Last Name:</p> <p>Date of Birth:</p> <p>Email:</p> <p>How do you prefer to be addressed? (Check <u>all</u> that apply)</p> <p> <input type="checkbox"/> She / Her <input type="checkbox"/> He/Him <input type="checkbox"/> Them/They <input type="checkbox"/> Dr. <input type="checkbox"/> Legal last name <input type="checkbox"/> Legal first name </p> <p> <input type="checkbox"/> Other Name: <input type="checkbox"/> Other gender pronoun: </p> <p>What language do you prefer to communicate in? (Check <u>all</u> that apply)</p> <p> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Other: </p>	<p>Legal First Name:</p> <p>Age:</p> <p>Phone:</p>
--	---

2. Referring provider's name and contact information:

Name:	Phone:	Contact address:
<p>How many doctors or health care providers have you seen in the past for your <u>pelvic pain</u>?</p> <p> <input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> >10 </p>		

3. Demographic information:

<p>What race and ethnicity best describes you? (Check <u>all</u> that apply)</p> <p> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander </p> <p> <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Middle Eastern </p> <p> <input type="checkbox"/> Hispanic or Latino/a/x <input type="checkbox"/> Other: </p>	
<p>What is your relationship status? (Check <u>all</u> that apply)</p> <p> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/> Casually dating </p> <p><input type="checkbox"/> Other:</p>	
<p>Describe your sexual practices: (Check <u>all</u> that apply)</p> <p> <input type="checkbox"/> NOT sexually active / abstinent <input type="checkbox"/> Asexual (without sexual feelings or associations) </p> <p> <input type="checkbox"/> Sexually active with men <input type="checkbox"/> Sexually active with women <input type="checkbox"/> Sexually active with both </p> <p><input type="checkbox"/> Other:</p>	
<p>With whom do you live? (Check <u>all</u> that apply)</p> <p> <input type="checkbox"/> Alone <input type="checkbox"/> Partner <input type="checkbox"/> Parents <input type="checkbox"/> Other Family <input type="checkbox"/> Friends <input type="checkbox"/> Homeless <input type="checkbox"/> Other: </p>	
<p>What is your education? (Check <u>only one</u>)</p> <p> <input type="checkbox"/> Less than 12 years <input type="checkbox"/> High School graduate <input type="checkbox"/> College degree <input type="checkbox"/> Postgraduate degree </p>	
<p>What type of work are you doing? (Check <u>only one</u>)</p> <p> <input type="checkbox"/> Unemployed <input type="checkbox"/> Work outside home <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Disabled </p>	

4. Medical History

Please list your medical or health problems, describe when the condition was diagnosed and whether it is controlled.

Medical Problem	Year Diagnosed	Controlled?
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>


5. Surgical History

Please check if you have had any of the following surgeries

Procedure	Date	Surgeon	Findings
Cystoscopy (looking inside the bladder) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Laparoscopy w/removal of Endometriosis <input type="checkbox"/> Yes <input type="checkbox"/> No			
Hysterectomy (removal of uterus and cervix) Were your ovaries removed? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the cervix retained (Supra-cervical hysterectomy)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Myomectomy <input type="checkbox"/> Yes <input type="checkbox"/> No			
Endoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No			
Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ovarian Cyst Removal <input type="checkbox"/> Yes <input type="checkbox"/> No			
Cesarean Delivery <input type="checkbox"/> Yes <input type="checkbox"/> No			
Appendectomy (appendix removal) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prostatectomy <input type="checkbox"/> Yes <input type="checkbox"/> No			
Colectomy (removal of colon) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Vasectomy <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other:			

6. Menstrual, Birth Control and Sexually Transmitted Infections History

If you **DO NOT** menstruate, select the reason(s) why: *(Check all that apply)*

- ☐ Had a hysterectomy ☐ Menopause ☐ Assigned MALE at birth *then skip to* 
☐ On continuous menstrual suppression using birth control (e.g. Depoprovera, pills, Progesterone IUD)
☐ Had an Endometrial ablation

When was your last menstrual period?

How old were you when your menstrual cycles started?

If you menstruate, do you **CURRENTLY** have any of the following symptoms **DURING** menstruation? *(Check all that apply)*

- ☐ Heavy bleeding ☐ Severe pain ☐ Irregular bleeding (more than once a month) ☐ Bleeding > 7 days
☐ Mood swings ☐ Fatigue ☐ Breast tenderness ☐ Constipation ☐ Diarrhea ☐ Headaches


If you have painful periods, how long have you had this type of pain? Please specify years or months.

Do you **CURRENTLY** regularly (more than 3 times a month) miss school or work due to your painful period?

- ☐ Yes ☐ No

If you have painful periods, have you used any of the following to help with your pain during your period? *(Check all that apply)*

- ☐ Birth Control Pill ☐ Vaginal ring ☐ Depo Provera ☐ Hormonal IUD
☐ NSAIDS (e.g. Ibuprofen, Naproxen) ☐ Acetaminophen ☐ Other:

What are you using for birth control / contraception? *(Check all that apply)* 

- ☐ Nothing ☐ Vasectomy ☐ Condoms ☐ Birth control pills ☐ Depoprovera injection
☐ Nexplanon implant ☐ Vaginal ring (NuvaRing) ☐ Tubal Ligation
☐ Hormonal IUD ☐ Non-Hormonal IUD Other:

Have you ever had any sexually transmitted infections (STIs)? *(Check all that apply)*

- ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV (Human Papilloma Virus) ☐ Syphilis
☐ PID (Pelvic Inflammatory Disease) ☐ HIV ☐ Hepatitis B ☐ Hepatitis C

7. Allergies and Current Medications

Please list your allergies:

Allergy	Reaction, what happens when you have this allergy?	Have you had treatments in the past for this allergy?

Please list all **CURRENT** medications you are taking, including herbal remedies:

Medication or Herbal Remedies	Dose	For what medical condition

8. Pregnancy / Obstetric History

How many pregnancies have you had? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

How many deliveries have you had? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

How many deliveries were vaginal? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

How many deliveries were cesarean? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

How many were miscarriages or abortions? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

Where there any complications during pregnancy, labor, delivery, or postpartum?

☐ Laceration 3°- 4° ☐ Vacuum/ Forceps ☐ Wound complication ☐ Other

9. Family History

Has anyone in your family had any of the following condition(s)? (Check all that apply)

- ☐ Endometriosis ☐ Fibromyalgia ☐ Chronic pelvic pain ☐ Irritable bowel syndrome ☐ Interstitial Cystitis
☐ Colon Cancer ☐ Breast Cancer ☐ Uterine Cancer ☐ Ovarian Cancer ☐ Depression
☐ Chronic Fatigue Syndrome ☐ Anxiety/Panic Attacks ☐ Temporomandibular Joint Disorder (TMD)
☐ Migraine Headache ☐ Post-Traumatic Stress Disorder (PTSD)
☐ Other Chronic Condition:

10. Pain History, Description and Contributing Factors

When did your pain begin? Month: Year: ☐ Unsure

Please use your own words to describe your pain:

How did your main pain begin, do you recall a specific incident that occurred when your pain first began? (*Check one*)

- ☐ Injury at home ☐ Injury at work/school ☐ Injury in other setting ☐ Motor vehicle crash
☐ After surgery ☐ Cancer ☐ Medical condition other than cancer
☐ No obvious cause/ do not know a specific incident ☐ Other:

How did your pain begin? (*Check only one*) ☐ Suddenly ☐ Gradually

How long has your main pain been present? (*Check only one*)

- ☐ Less than 3 months ☐ 3-12 months ☐ 12 months-2 years ☐ 2-5 years ☐ More than 5 years

Since your pain began, is your pain: (*Check only one*)

- ☐ No different ☐ Getting better ☐ Getting worse ☐ I don't know

Which statement best describes your pain? (*Check only one*)

- ☐ Always present (always the same intensity)
☐ Always present (level of pain varies)
☐ Often present (pain free periods less than 6 hours)
☐ Occasionally present (once to several times per day lasting up to an hour)
☐ Rarely present (pain occurs every few days or weeks)

How would you describe your pain: (*Check all that apply*)

- ☐ Sharp, stabbing ☐ Crampy ☐ Heavy feeling in the pelvis ☐ Dull, achy pain
☐ Pulling, tugging pain ☐ Throbbing pain ☐ Burning pain ☐ Falling out sensation
☐ Other:

Does your pain ever wake you up from your sleep? ☐ Yes ☐ No

Does your pain ever radiate or spread to other regions of your body? ☐ Yes ☐ No

What makes your pain **WORSE**? (*Check all that apply*)

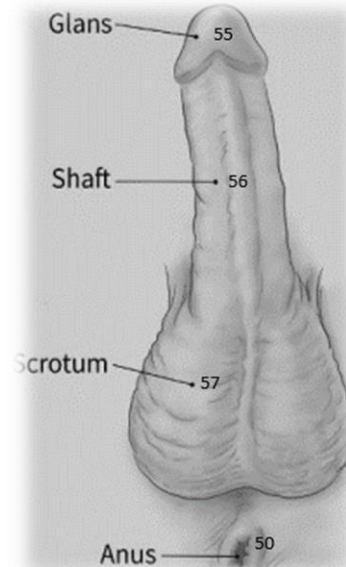
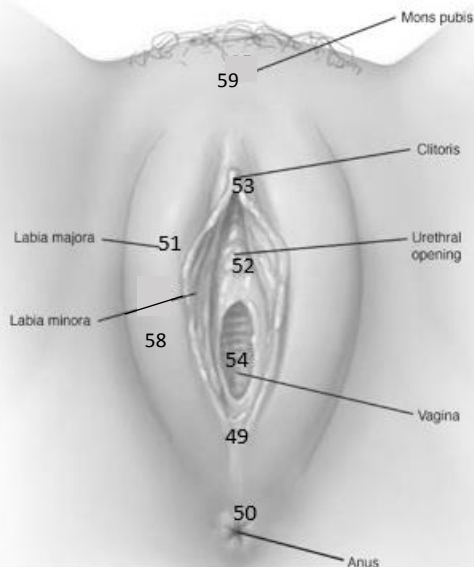
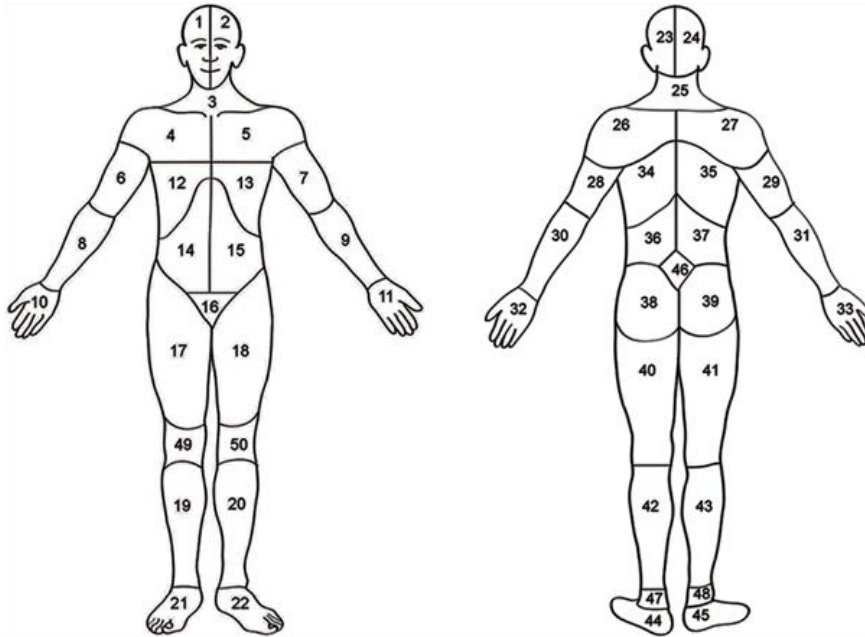
- ☐ Walking ☐ Climbing stairs ☐ Urination ☐ Heavy lifting ☐ **Nothing makes it worse**
☐ Full bladder ☐ Stress ☐ Housework ☐ The weather ☐ Getting in/out of the car
☐ Exercise ☐ Menstrual period ☐ Contact with clothing ☐ Intercourse/ Sexual contact
☐ Bowel movements ☐ Other:

What makes your pain **BETTER**? (*Check all that apply*)

- ☐ Lying down/rest ☐ Emptying bladder ☐ Ice or Heating pad ☐ **Nothing makes it better**
☐ Meditation ☐ Laxatives/enema ☐ It goes away by itself ☐ When I feel supported
☐ Hot bath ☐ Massage ☐ Bowel movements ☐ When my stress is low
☐ Exercise ☐ Ibuprofen or Tylenol ☐ Prescription pain medications
☐ Being distracted, when I am busy doing other things ☐ Other:

11. Pain Location, Severity Scales and Past Treatments

Please mark **ALL** areas where you have pain on the Body Maps below as they apply to you. Please shade or circle each area of pain.



Short McGill Questionnaire

List each <u>pain location number from the body map in the first column</u> . Then, select the length, quality and severity of pain at each location. [IF YOU HAVE MORE THAN 3 AREAS OF PAIN, FILL THIS FOR YOUR 3 WORSE AREAS]			
Example			
(if 1 is by your pelvis it means the pain is in your pelvis) 1	<input type="checkbox"/> 1 year <input checked="" type="checkbox"/> 1-3 years <input type="checkbox"/> 4-7 years <input type="checkbox"/> 8-10 years <input type="checkbox"/> More than 10 years	<input checked="" type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Sharp <input type="checkbox"/> Cramping <input type="checkbox"/> Gnawing <input type="checkbox"/> Hot-Burning <input checked="" type="checkbox"/> Aching <input type="checkbox"/> Heavy <input type="checkbox"/> Tender <input type="checkbox"/> Splitting <input type="checkbox"/> Tiring-Exhausting <input type="checkbox"/> Sickening <input type="checkbox"/> Fearful <input type="checkbox"/> Punishing-Cruel	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input checked="" type="checkbox"/> Severe
This means you've had severe throbbing, aching, pelvic pain for 1-3 years.			
Location Number:	<input type="checkbox"/> 1 year <input type="checkbox"/> 1-3 years <input type="checkbox"/> 4-7 years <input type="checkbox"/> 8-10 years <input type="checkbox"/> More than 10 years	<input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Sharp <input type="checkbox"/> Cramping <input type="checkbox"/> Gnawing <input type="checkbox"/> Hot-Burning <input type="checkbox"/> Aching <input type="checkbox"/> Heavy <input type="checkbox"/> Tender <input type="checkbox"/> Splitting <input type="checkbox"/> Tiring-Exhausting <input type="checkbox"/> Sickening <input type="checkbox"/> Fearful <input type="checkbox"/> Punishing-Cruel	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Location Number:	<input type="checkbox"/> 1 year <input type="checkbox"/> 1-3 years <input type="checkbox"/> 4-7 years <input type="checkbox"/> 8-10 years <input type="checkbox"/> More than 10 years	<input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Sharp <input type="checkbox"/> Cramping <input type="checkbox"/> Gnawing <input type="checkbox"/> Hot-Burning <input type="checkbox"/> Aching <input type="checkbox"/> Heavy <input type="checkbox"/> Tender <input type="checkbox"/> Splitting <input type="checkbox"/> Tiring-Exhausting <input type="checkbox"/> Sickening <input type="checkbox"/> Fearful <input type="checkbox"/> Punishing-Cruel	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Location Number:	<input type="checkbox"/> 1 year <input type="checkbox"/> 1-3 years <input type="checkbox"/> 4-7 years <input type="checkbox"/> 8-10 years <input type="checkbox"/> More than 10 years	<input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Sharp <input type="checkbox"/> Cramping <input type="checkbox"/> Gnawing <input type="checkbox"/> Hot-Burning <input type="checkbox"/> Aching <input type="checkbox"/> Heavy <input type="checkbox"/> Tender <input type="checkbox"/> Splitting <input type="checkbox"/> Tiring-Exhausting <input type="checkbox"/> Sickening <input type="checkbox"/> Fearful <input type="checkbox"/> Punishing-Cruel	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

Indicate on this line by checking a box to describe how bad your **MAIN** pain is:

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	-----------------------------

No Pain
Worse imaginable pain

Rate the **SEVERITY OF YOUR PAIN (YOUR WORSE OR MAIN PAINFUL AREA)** on the scales below:

In the past 7 days	Had no pain	Mild	Moderate	Severe	Very severe
1. How intense was your pain at its worse?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. How intense was your average pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. What is your level of pain right now?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Mark the one box that describes how much, during the past week, pain has interfered with:

	0= does NOT interfere completely interferes=10										
General activity	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Mood	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Walking activity	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Normal activity (outside the home or with housework)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Relations with other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Sleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Enjoyment of life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10

Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Please read each statement and circle a number 0,1,2,3, or 4 which indicates how much the statement applies to you when you are experiencing pain.

PCS

When I am in pain...	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel I can't go on	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
It's terrible and I think it's never going to get any better	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
It's awful and I feel it overwhelms me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel I can't stand it anymore	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I become afraid that the pain will get worse	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I keep thinking of other painful events	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I anxiously want the pain to go away	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I can't seem to keep it out of my mind	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I keep thinking about how much it hurts	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I keep thinking about how badly I want the pain to stop	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
There's nothing I can do to reduce the intensity of the pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I wonder whether something serious may happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

If assigned FEMALE at birth, complete this questionnaire to assess the impact of your pain on your sexuality.

Interest in Sexual activity in the PAST 30 DAYS						
1. How interested have you been in sexual activity?	Not at all <input type="checkbox"/> 1	A little bit <input type="checkbox"/> 2	Somewhat <input type="checkbox"/> 3	Quite a bit <input type="checkbox"/> 4	Very <input type="checkbox"/> 5	
2. How often have you felt like you wanted to have sex?	Never <input type="checkbox"/> 1	Rarely <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 3	Often <input type="checkbox"/> 4	Always <input type="checkbox"/> 5	
Lubrication over the PAST 4 WEEKS...						
3. How often did you become lubricated 'wet' during sexual activity or intercourse?	No sexual activity <input type="checkbox"/> 0	Almost always or always <input type="checkbox"/> 5	Most times (more than half the time) <input type="checkbox"/> 4	Sometimes (about half the time) <input type="checkbox"/> 3	A few times (less than half of the time) <input type="checkbox"/> 2	Almost never or ever <input type="checkbox"/> 1
In the past 30 days...						
4. How difficult has it been for your vagina to be lubricated or 'wet' when you wanted it to?	Not at all <input type="checkbox"/> 1	A little bit <input type="checkbox"/> 2	Somewhat <input type="checkbox"/> 3	Quite a bit <input type="checkbox"/> 4	Very <input type="checkbox"/> 5	
Vaginal Discomfort in the PAST 30 DAYS...						
5. How would you describe the comfort of your vagina during sexual activity?	Have not had any sexual activity in the past 30 days <input type="checkbox"/> 0	Never <input type="checkbox"/> 1	Rarely <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 3	Often <input type="checkbox"/> 4	Always <input type="checkbox"/> 5
6. How often have you had difficulty with sexual activity because of discomfort or pain in your vagina?	Have not had any sexual activity in the past 30 days <input type="checkbox"/> 0	Never <input type="checkbox"/> 1	Rarely <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 3	Often <input type="checkbox"/> 4	Always <input type="checkbox"/> 5
7. How often have you stopped sexual activity because of discomfort or pain in your vagina?	Have not had any sexual activity in the past 30 days <input type="checkbox"/> 0	Never <input type="checkbox"/> 1	Rarely <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 3	Often <input type="checkbox"/> 4	Always <input type="checkbox"/> 5
Orgasm in the PAST 30 DAYS...						
8. How would you rate your ability to have a satisfying orgasm/climax?	Have not tried to have an orgasm/climax in the past 30 days <input type="checkbox"/> 0	Excellent <input type="checkbox"/> 5	Very good <input type="checkbox"/> 4	Good <input type="checkbox"/> 3	Fair <input type="checkbox"/> 2	Poor <input type="checkbox"/> 1
Satisfaction in the PAST 30 DAYS...						
9. When you have had sexual activity how much have you enjoyed it?	Have not had any sexual activity in the past 30 days <input type="checkbox"/> 0	Not at all <input type="checkbox"/> 1	A little bit <input type="checkbox"/> 2	Somewhat <input type="checkbox"/> 3	Quite a bit <input type="checkbox"/> 4	Very <input type="checkbox"/> 5
10. When you have had sexual activity, how satisfying has it been?	Have not had any sexual activity in the past 30 days <input type="checkbox"/> 0	Not at all <input type="checkbox"/> 1	A little bit <input type="checkbox"/> 2	Somewhat <input type="checkbox"/> 3	Quite a bit <input type="checkbox"/> 4	Very <input type="checkbox"/> 5

If assigned **MALE** at birth, complete this questionnaire to assess the impact of your pain on your sexuality.

Interest in Sexual activity in the PAST 30 DAYS

How interested have you been in sexual activity?	Not at all <input type="checkbox"/> 1	A little bit <input type="checkbox"/> 2	Somewhat <input type="checkbox"/> 3	Quite a bit <input type="checkbox"/> 4	Very <input type="checkbox"/> 5
How often have you felt like you wanted to have sex?	Never <input type="checkbox"/> 1	Rarely <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 3	Often <input type="checkbox"/> 4	Always <input type="checkbox"/> 5

Erectile function, in the PAST 30 DAYS

In the past 30 days...

How difficult has it been for you to get an erection when you wanted to? (If you use pills, injections, or a penis pump to help you get an erection, please answer this question thinking about the times that you used these aids)	Have not tried to get an erection in the past 30 days <input type="checkbox"/> 0	Not at all <input type="checkbox"/> 5	A little bit <input type="checkbox"/> 4	Somewhat <input type="checkbox"/> 3	Quite a bit <input type="checkbox"/> 2	Very <input type="checkbox"/> 1
---	---	--	--	--	---	------------------------------------

In the PAST 30 DAYS...

How difficult has it been to keep an erection (stay hard) when you wanted to? (If you use pills, injections, or a penis pump to help you get an erection, please answer this question thinking about the times that you used these aids)	Have not had erection in the past 30 days <input type="checkbox"/> 0	Not at all <input type="checkbox"/> 5	A little bit <input type="checkbox"/> 4	Somewhat <input type="checkbox"/> 3	Quite a bit <input type="checkbox"/> 2	Very <input type="checkbox"/> 1
--	---	--	--	--	---	------------------------------------

How would you rate the following in the LAST 4 WEEKS

Your ability to have an erection	Very poor <input type="checkbox"/> 1	Poor <input type="checkbox"/> 2	Fair <input type="checkbox"/> 3	Good <input type="checkbox"/> 4	Very good <input type="checkbox"/> 5
----------------------------------	---	------------------------------------	------------------------------------	------------------------------------	---

Orgasm in the PAST 30 DAYS...

How would you rate your ability to have a satisfying orgasm/climax?	Have not tried to have an orgasm/climax in the past 30 days <input type="checkbox"/> 0	Excellent <input type="checkbox"/> 5	Very good <input type="checkbox"/> 4	Good <input type="checkbox"/> 3	Fair <input type="checkbox"/> 2	Poor <input type="checkbox"/> 1
---	---	---	---	------------------------------------	------------------------------------	------------------------------------

Satisfaction in the PAST 30 DAYS...

When you have had sexual activity how much have you enjoyed it?	Have not had any sexual activity in the past 30 days <input type="checkbox"/> 0	Not at all <input type="checkbox"/> 1	A little bit <input type="checkbox"/> 2	Somewhat <input type="checkbox"/> 3	Quite a bit <input type="checkbox"/> 4	Very <input type="checkbox"/> 5
When you have had sexual activity, how satisfying has it been?	Have not had any sexual activity in the past 30 days <input type="checkbox"/> 0	Not at all <input type="checkbox"/> 1	A little bit <input type="checkbox"/> 2	Somewhat <input type="checkbox"/> 3	Quite a bit <input type="checkbox"/> 4	Very <input type="checkbox"/> 5

REGARDLESS OF YOUR GENDER, please respond to each question or statement ABOUT YOUR GENERAL HEALTH by marking 1 box per row.

In general, would you say your health is?	Excellent <input type="checkbox"/> 5	Very good <input type="checkbox"/> 4	Good <input type="checkbox"/> 3	Fair <input type="checkbox"/> 2	Poor <input type="checkbox"/> 1
In general, would you say your quality of life is?	Excellent <input type="checkbox"/> 5	Very good <input type="checkbox"/> 4	Good <input type="checkbox"/> 3	Fair <input type="checkbox"/> 2	Poor <input type="checkbox"/> 1
In general, how would you rate your physical health?	Excellent <input type="checkbox"/> 5	Very good <input type="checkbox"/> 4	Good <input type="checkbox"/> 3	Fair <input type="checkbox"/> 2	Poor <input type="checkbox"/> 1
In general, how would you rate your mental health, including mood and your ability to think?	Excellent <input type="checkbox"/> 5	Very good <input type="checkbox"/> 4	Good <input type="checkbox"/> 3	Fair <input type="checkbox"/> 2	Poor <input type="checkbox"/> 1
In general, how would you rate your satisfaction with your social activities and relationships?	Excellent <input type="checkbox"/> 5	Very good <input type="checkbox"/> 4	Good <input type="checkbox"/> 3	Fair <input type="checkbox"/> 2	Poor <input type="checkbox"/> 1
In general, please rate how well you carry out your usual social activities and roles (this includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	Excellent <input type="checkbox"/> 5	Very good <input type="checkbox"/> 4	Good <input type="checkbox"/> 3	Fair <input type="checkbox"/> 2	Poor <input type="checkbox"/> 1
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair	Completely <input type="checkbox"/> 5	Mostly <input type="checkbox"/> 4	Moderately <input type="checkbox"/> 3	A little <input type="checkbox"/> 2	Not at all <input type="checkbox"/> 1
<i>In the past 7 days...</i>					
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	Never <input type="checkbox"/> 1	Rarely <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 3	Often <input type="checkbox"/> 4	Always <input type="checkbox"/> 5
How would you rate your fatigue on average?	None <input type="checkbox"/> 1	Mild <input type="checkbox"/> 2	Moderate <input type="checkbox"/> 3	Severe 4 <input type="checkbox"/>	Very severe <input type="checkbox"/> 5
How would you rate your pain on average?	<input type="checkbox"/> 0-no pain <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <div style="text-align: right;">Worst imaginable pain</div>				

PROMIS Global Health v.1.1

[For health care providers-PROMIS scoring methods <http://www.healthmeasures.net/score-and-interpret/calculate-scores>]

What medications have you tried in the PAST for your pelvic pain? (Check all that apply)

Medication	Currently on Medication	Have tried this medication in the past	Did you find this medication helpful?
Gabapentin (Neurontin®)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat <input type="checkbox"/>
Pregabalin (Lyrica®)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat <input type="checkbox"/>
Amitriptyline (Elavil®)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat <input type="checkbox"/>
Duloxetine (Cymbalta®)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat <input type="checkbox"/>
Milnacipran (Savella®)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat <input type="checkbox"/>
Trazodone	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat <input type="checkbox"/>
Oral Muscle relaxer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat <input type="checkbox"/>
Diazepam Suppository (Valium®)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat <input type="checkbox"/>
Opioids	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat <input type="checkbox"/>
Other Medication not listed:			

What OTHER TREATMENTS have you tried for your pelvic pain IN THE PAST? (Check all that apply)

- ☐ Acupuncture ☐ Massage ☐ Nutrition/Diet ☐ Physical Therapy ☐ Biofeedback
☐ Trigger Point Injections ☐ TENS Unit ☐ Botox Injections ☐ Nerve Blocks
☐ Epidural ☐ Sex therapy ☐ Joint Injections ☐ Neurostimulation
☐ Bladder instillations ☐ Aqua therapy ☐ Cognitive Behavioral Therapy
☐ Radio Frequency Ablation (RFA) ☐ NONE
☐ Hormonal treatment-- if yes, what type of hormonal treatment? (**Check all that apply**)
 ☐ Pills ☐ Patch ☐ Ring ☐ Injections ☐ Estrogen ☐ Progesterone

Other treatments:

12. *Gastrointestinal History*

Do you have any of the following GASTROINTESTINAL (BOWEL) symptoms? (Check all that apply)

- Nausea/vomiting? ☐ Yes ☐ No Constipation: ☐ Yes ☐ No
 Diarrhea: ☐ Yes ☐ No Reflux / Heartburn: ☐ Yes ☐ No
 Abdominal pain: ☐ Yes ☐ No
 Bloating: ☐ Yes ☐ No

Do you have increased pain with bowel movements? ☐ Yes ☐ No

Do you have any rectal bleeding or blood in your stool? ☐ Yes ☐ No








Have you ever seen a gastroenterologist (GI specialist)? ☐ Yes ☐ No

Do you have pain or discomfort that is associated with any of the following?

- Change in frequency of bowel movement? ☐ Yes ☐ No
 Change in appearance of stool or bowel movement? ☐ Yes ☐ No

Does your pain improve or get worse around times of having a bowel movement? ☐ Yes ☐ No

What do your stools look like **MOST** of the time? *Select one type from the chart*

<input type="checkbox"/>	Type 1		Separate hard lumps, like nuts (hard to pass)
<input type="checkbox"/>	Type 2		Sausage-shaped but lumpy
<input type="checkbox"/>	Type 3		Like a sausage but with cracks on its surface
<input type="checkbox"/>	Type 4		Like a sausage or snake, smooth and soft
<input type="checkbox"/>	Type 5		Soft blobs with clear cut edges (passed easily)
<input type="checkbox"/>	Type 6		Fluffy pieces with ragged edges, mushy stool
<input type="checkbox"/>	Type 7		Watery, no solid pieces, ENTIRELY LIQUID

13. Additional Symptoms and Diagnoses

Do you have pain in your vulva/labia, clitoris, scrotum, penis or anus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have numbness in the same area?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your pain worsened by sitting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the pain wake you up at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a pudendal nerve block?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, did you have improvement in pain (even if temporary)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had any severe sport injuries (e.g. injuries during running, lifting, gymnastics)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had any motor vehicle accident injuries to your head, neck, spine or back?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had any fall injuries (e.g. injuries to your back, tailbone, neck)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you ever been diagnosed, or treated for any of these conditions? (Check **all** that apply)

Condition		
Fibroids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Endometriosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic fatigue syndrome / Myeloencephalitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Interstitial cystitis / Bladder pain syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic low back pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic headaches or migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TMJ (Temporomandibular joint disorder)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abnormal pap smear	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other:		

14. Urinary History

Do you experience any of the following **URINARY SYMPTOMS**? (Check all that apply)

Loss of urine when coughing, sneezing, or laughing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty passing urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent bladder infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood in the urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Still feeling full after urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Having to urinate again within minutes of urinating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Urgency to go urinate	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If assigned **FEMALE** at birth, complete the bladder function and symptom questionnaire. Please respond to questions 4-6 **ONLY IF** you engage in sexual intercourse.

Pelvic Pain / Urinary Frequency Questionnaire	0	1	2	3	4
1. How many times do you go to the bathroom DURING THE DAY (to void or empty your bladder)?	3-6 <input type="checkbox"/>	7-10 <input type="checkbox"/>	11-14 <input type="checkbox"/>	15-19 <input type="checkbox"/>	20 or more <input type="checkbox"/>
2. How many times do you go to the bathroom AT NIGHT (to void or empty your bladder)?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 or more <input type="checkbox"/>
3. If you get up at night to void or empty your bladder does it bother you?	Never <input type="checkbox"/>	Mildly <input type="checkbox"/>	Moderately <input type="checkbox"/>	Severely <input type="checkbox"/>	
4. Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No					
5. If you are sexually active, do you now or have you ever, had pain or symptoms during or after sexual intercourse?	Never <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Usually <input type="checkbox"/>	Always <input type="checkbox"/>	
6. If you have pain with intercourse, does it make you avoid sexual intercourse?	Never <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Usually <input type="checkbox"/>	Always <input type="checkbox"/>	
7. Do you have pain associated with your bladder or in your pelvis (lower abdomen, labia, vagina, urethra, perineum)?	Never <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Usually <input type="checkbox"/>	Always <input type="checkbox"/>	
8. Do you have urgency after voiding?	Never <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Usually <input type="checkbox"/>	Always <input type="checkbox"/>	
9. If you have pain, is it usually	Never <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	
10. Does your pain bother you?	Never <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Usually <input type="checkbox"/>	Always <input type="checkbox"/>	
11. If you have urgency, is it usually		Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	
12. Does your urgency bother you?	Never <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Usually <input type="checkbox"/>	Always <input type="checkbox"/>	

If assigned **MALE** at birth, please complete the Chronic Prostatitis Symptom Index (NIH):

1. In the last week, have you experienced any pain or discomfort in the following areas?	
a. Area between rectum and testicles (perineum)	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No
b. Testicles	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No
c. Tip of penis (not related to urination)	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No
d. Below your waist, in your pubic or bladder area	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No
2. In the last week, have you experienced:	
a. Pain or burning during urination?	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No
b. Pain or discomfort during or after sexual climax (ejaculation)?	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No
3. How often have you had pain or discomfort in any of these areas (a-d) over the last week?	<input type="checkbox"/> 0 Never <input type="checkbox"/> 1 Rarely <input type="checkbox"/> 2 Sometimes <input type="checkbox"/> 3 Often <input type="checkbox"/> 4 Usually <input type="checkbox"/> 5 Always
4. Which number best describes your <u>AVERAGE</u> pain or discomfort on the days that you had it, over the last week?	No Pain <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 Worse imaginable pain
5. How often have you had the sensation of not emptying your bladder completely after you finished urinating, over the last week?	<input type="checkbox"/> 0 Not at all <input type="checkbox"/> 1 Less than 1 time in 5 <input type="checkbox"/> 2 Less than half the time <input type="checkbox"/> 3 About half the time <input type="checkbox"/> 4 More than Half the time <input type="checkbox"/> 5 Almost always
6. How often have you had to urinate again less than two hours after you finished urinating, over the last week	<input type="checkbox"/> 0 Not at all <input type="checkbox"/> 1 Less than 1 time in 5 <input type="checkbox"/> 2 Less than half the time <input type="checkbox"/> 3 About half the time <input type="checkbox"/> 4 More than Half the time <input type="checkbox"/> 5 Almost always
7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?	<input type="checkbox"/> 0 None <input type="checkbox"/> 1 Only a little <input type="checkbox"/> 2 Some <input type="checkbox"/> 3 A lot
8. How much did you think about your symptoms over the last week?	<input type="checkbox"/> 0 None <input type="checkbox"/> 1 Only a little <input type="checkbox"/> 2 Some <input type="checkbox"/> 3 A lot
8. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?	<input type="checkbox"/> 0 Delighted <input type="checkbox"/> 1 Pleased <input type="checkbox"/> 2 Mostly satisfied <input type="checkbox"/> 3 Mixed (equally satisfied and dissatisfied) <input type="checkbox"/> 4 Mostly dissatisfied <input type="checkbox"/> 5 Unhappy <input type="checkbox"/> 6 Terrible
Scoring	
Pain: Total of items 1a, 1b, 1c, 1d, 2a, 2b, 3 and 4 =	
Urinary symptoms: Total of times 5 and 6 =	
Quality of life impact: Total of times 7, 8 and 9 =	

1. Psychosocial History

What is the main source of stress in your life? ☐ Work ☐ Family ☐ Financial ☐ Social ☐ Relationships

Who are the people you talk to concerning your pain, during stressful times?

- ☐ Spouse/ Partner ☐ Relative ☐ Support Group ☐ Clergy ☐ Doctor/Nurse
☐ Friend ☐ Mental Health Provider ☐ I take care of myself

Have you ever experienced abuse or trauma as a child (13 years or younger)? (Check all that apply)

- ☐ Emotional ☐ Physical ☐ Sexual ☐ Domestic Violence

Have you ever experienced abuse as an adult?

- ☐ Emotional ☐ Physical ☐ Sexual ☐ Domestic Violence

Are you currently experiencing abuse?

- ☐ Emotional ☐ Physical ☐ Sexual ☐ Domestic Violence

Have you ever received mental health treatment?

- ☐ Medications ☐ Therapy ☐ Hospitalization

Are you currently still receiving mental health treatment? ☐ Yes ☐ No

If yes, please explain:

Do you have a history of?

- ☐ Depression ☐ Anxiety ☐ Panic Attacks ☐ Bipolar Disorder
☐ Trauma ☐ PTSD ☐ Disordered eating ☐ None of these

Compared to other stressors in your life, how does your pain compare in importance?

- ☐ Most important ☐ One of many problems

Are there relationships you think that may be contributing to your symptoms? ☐ Yes ☐ No

Do those that are in your daily life understand you? ☐ Yes ☐ No

If you have a partner, would you characterize them as supportive? ☐ Yes ☐ No

Does your partner notice if you are in pain? ☐ Yes ☐ No

How does your partner react when you hurt? Please explain:

Do you believe that your pain impacts other areas of your life?

- ☐ Education ☐ Family ☐ Recreational activities
☐ Work ☐ Friends ☐ Sexual intimacy

Please read each statement and circle a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the past week. There are no wrong or right answers, do not spend too much time on any statement.

DASS-21	Not at all	Some of the time	A good part of the time	Most of the time
I found it hard to wind down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I was aware of dryness of my mouth	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I couldn't seem to experience any positive feeling at all	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I found it difficult to work up the initiative to do things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I tended to overreact to situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I experienced trembling (e.g. in the hands)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I felt that I was using a lot of nervous energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I was worried about situations in which I might panic and make a fool of myself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I felt that I had nothing to look forward to	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I found myself getting agitated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I found it difficult to relax	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I felt down-hearted and blue	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I was intolerant of anything that kept me from getting on with what I was doing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I felt I was close to panic	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I was unable to become enthusiastic about anything	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I felt I wasn't worth much as a person	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I felt that I was rather touchy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I was aware of the action of my heart in the absence of physical exertion (e.g. a sense of heart rate increase, heart missing a beat)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I felt scared without good reason	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
I felt scared without good reason	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Do you **CURRENTLY** use, or have you used any of the following substances in the **PAST 12 MONTHS**? (Check all that apply)

Substance			How many times a week?	Do you use this for pain control?
Do you drink any alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <1 <input type="checkbox"/> 2-3 <input type="checkbox"/> >4	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco or Nicotine Products	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <1 <input type="checkbox"/> 2-3 <input type="checkbox"/> >4	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cocaine / Crack	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <1 <input type="checkbox"/> 2-3 <input type="checkbox"/> >4	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heroin	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <1 <input type="checkbox"/> 2-3 <input type="checkbox"/> >4	<input type="checkbox"/> Yes <input type="checkbox"/> No
Opioids	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <1 <input type="checkbox"/> 2-3 <input type="checkbox"/> >4	<input type="checkbox"/> Yes <input type="checkbox"/> No
Methamphetamines	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <1 <input type="checkbox"/> 2-3 <input type="checkbox"/> >4	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stimulants	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <1 <input type="checkbox"/> 2-3 <input type="checkbox"/> >4	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ecstasy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <1 <input type="checkbox"/> 2-3 <input type="checkbox"/> >4	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychedelics	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <1 <input type="checkbox"/> 2-3 <input type="checkbox"/> >4	<input type="checkbox"/> Yes <input type="checkbox"/> No
Marijuana/THC/Cannabis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <1 <input type="checkbox"/> 2-3 <input type="checkbox"/> >4	<input type="checkbox"/> Yes <input type="checkbox"/> No

Thank you for taking the time to complete this form. This information will help your health care provider take better care of you.

For more information on chronic pelvic pain and how to prepare for your clinical evaluation, visit the 'patient resources' and 'pamphlets' section of the International Pelvic Pain Society web at www.pelvicpain.org.

FOR OFFICE USE ONLY:

Form reviewed by (Name):

Date of Review:

Health Care Provider Comments: