



**U.S. Naval Hospital Naples
Pelvalgia Clinic Questionnaire**

The following questions make up a screening questionnaire that will help us in caring for you during your evaluation. Your answers may indicate whether certain tests would be appropriate in helping to evaluate your symptoms or condition. If you have any questions, please ask your health care provider.

Name _____ SSN (of sponsor if dependent) _____ FMP _____

Rank/Rate(active duty) _____ Duty Station _____ Phone# (H) _____ (W) _____

Age _____ HT _____ WT _____ Race _____ Religious Preference _____

Primary Language _____ Single _____ Married _____ Divorced _____ Widowed _____

Husband/Partner _____ Rank/Rate (if AD) _____ Race _____

Duty Station _____ Phone # _____

Address _____

E-mail _____

GYNECOLOGICAL & MENSTRUAL HISTORY

How long has you had any of these problems ____mos ____yrs

Do you have any of the following problems:	YES	NO
1. Blood in the urine	_____	_____
2. Recurrent urinary tract infections	_____	_____
3. Voids per day _____		
4. Voids per night _____		
5. Leakage of urine		
If yes, number of leaks per day _____ week _____ month _____		
Amount of leak:		
Few drops _____		
Wetting a pad _____		
Fully soaking underwear w/wo pad _____		

PATIENT IDENTIFICATION

- | | | YES | NO |
|-----|---|------------|------------|
| 6. | Are you aware when your bladder is full? | ___ | ___ |
| 7. | Are you aware when you're wet? | ___ | ___ |
| 8. | Do you have pain with urination? | ___ | ___ |
| 9. | Do you have pain with filling of the bladder?
If yes, does the pain go away with urination? | ___
___ | ___
___ |
| 10. | Do you have pelvic pressure? | ___ | ___ |
| 11. | Do you sense a bulge in the vagina? | ___ | ___ |
| 12. | Have you ever used a pessary for this problem?
If yes, what type? _____ | ___ | ___ |
| 13. | Have you ever been told you have endometriosis? | ___ | ___ |
| 14. | Have you ever been told you do not have endometriosis? | ___ | ___ |
| 15. | Have you ever been told you have interstitial cystitis? | ___ | ___ |
| 16. | Have you ever been told you do not have interstitial cystitis? | ___ | ___ |
| 17. | How long have you had pain? Months _____ Years _____ | | |
| 18. | If you have urinary urgency (the pressure to urinate),
how long have you had it? Months _____ Years _____ | | |
| 19. | Do you have pollen allergies? | ___ | ___ |
| 20. | Are you taking medications for pain?
If yes, what do you take? _____
How many per day? _____ | ___ | ___ |
| 21. | Do you have any female relatives who have a similar problem with
pelvic pain?
If yes, who? Please check all that apply

___ Mother ___ Grandmother ___ Aunt ___ Sister

___ Daughter ___ Granddaughter ___ Don't Know | ___ | ___ |
| 22. | Do you have any female relatives who have problems
with urinary frequency or recurrent urinary tract infections?
If yes, who? Please check all that apply

___ Mother ___ Grandmother ___ Aunt ___ Sister

___ Daughter ___ Granddaughter ___ Don't Know | ___ | ___ |
| 23. | Have you had any previous surgeries for your pelvic pain?
If yes, how many? _____ | ___ | ___ |

PATIENT IDENTIFICATION

- | | YES | NO |
|--|-------|-------|
| 38. Does your pelvic pain seem to be worse during particular parts of your menstrual cycle?
If yes, when is the pain worse? Please check all that apply | _____ | _____ |
| _____ During period | | |
| _____ First week after period ends | | |
| _____ Second week after period ends | | |
| _____ Third week after period ends | | |
| 39. Do you usually have severe cramping with your periods? _____ | | |
| 40. What was the first day of your last NORMAL period? _____ | | |
| 41. Have you had the following: | | |
| a. unusual breast lumps or discharge from the nipples | _____ | _____ |
| b. repeated vaginal infections, pelvic inflammatory disease | _____ | _____ |
| c. abnormal pap smears | _____ | _____ |
| d. sexually transmitted diseases | _____ | _____ |
| e. infections of the uterus, tubes or ovaries | _____ | _____ |
| f. a diagnosis of pelvic inflammatory disease | _____ | _____ |
| g. surgery of your tubes, ovaries, uterus or vagina | _____ | _____ |
| h. any symptoms of hot flushes, difficulty sleeping, mood swings | _____ | _____ |

OBSTETRIC HISTORY

1. Number of past pregnancies _____
2. Number of miscarriages and/or abortions _____
3. Number of children now living _____ Term _____ Preterm _____
If yes, answer **DATE, WEIGHT** and **METHOD OF DELIVERY**. Largest baby weight _____ LBS

MEDICAL HISTORY

- | | YES | NO |
|--|-------|-------|
| 1. Have you ever been hospitalized
If so, for what diagnosis
_____ | _____ | _____ |
| 2. Do you have any chronic health problems? | _____ | _____ |
| 3. Do you routinely have headaches? | _____ | _____ |
| 4. Do you have, or have you ever had, seizures or convulsions? | _____ | _____ |
| 5. Do you have any problems with your vision or eyes?
(not including wearing contacts or glasses) | _____ | _____ |
| 6. Have you ever had problems with your thyroid gland?
What? _____ | _____ | _____ |
| 7. Have you ever had problems with your lungs?
(i.e. pneumonia, asthma, bronchitis, tuberculosis) | _____ | _____ |

PATIENT IDENTIFICATION

- | | | YES | NO |
|-----|--|------------|-----------|
| 8. | Have you ever had problems with your heart?
(i.e. heart murmur, rheumatic heart disease, heart surgery,
"heart attack", high blood pressure) | _____ | _____ |
| 9. | Do you have problems with your stomach or intestines,
i.e. constipation, diarrhea, hemorrhoids ? | _____ | _____ |
| 10. | Have you ever had a blood transfusion?
When? _____ | _____ | _____ |
| 11. | Have you been told by a health care provider that you are anemic?
When? _____ | _____ | _____ |
| 12. | Are you seeing a health care provider
for problems with your muscles or bones? | _____ | _____ |
| 13. | Do you have any other health problems that we should know about?
Explain: _____

_____ | _____ | _____ |
| 14. | Psychiatric problems or medications?
Please specify _____
_____ | _____ | _____ |

MEDICATIONS

- | | | YES | NO |
|----|--|------------|-----------|
| 1. | Do you take any medications routinely? Please list all medications
What and how often? _____

_____ | _____ | _____ |

ALLERGIES

- | | | YES | NO |
|----|---|------------|-----------|
| 1. | Do you have allergies to any medications?
If yes, which medication and what type of reaction? _____
_____ | _____ | _____ |
| 2. | Do you have allergies to any foods? _____ | _____ | _____ |
| 3. | Do you have a latex allergy? | _____ | _____ |

SURGICAL HISTORY

- | | | YES | NO |
|----|---|------------|-----------|
| 1. | Have you ever had any operations or surgeries?
What and when? _____ year _____
_____ year _____
_____ year _____
_____ year _____
_____ year _____ | _____ | _____ |

PATIENT IDENTIFICATION

SOCIAL HISTORY

- | | | YES | NO |
|----|--|------------|-----------|
| 1. | Do you smoke?
How many packs/day? _____ How many years? _____ | _____ | _____ |
| 2. | Do you drink alcoholic beverages?
How many drinks/week? _____ | _____ | _____ |
| 3. | Do you/have you used illicit or illegal drugs
if so, what _____ | _____ | _____ |
| 4. | Are you currently employed
if so, what _____
What type of job? _____ | _____ | _____ |
| 5. | Are you married?
If YES, how many years? _____ years | _____ | _____ |
| 6. | Have you ever been the victim of sexual, physical or emotional abuse? | _____ | _____ |

EDUCATIONAL HISTORY

- How many years of school have you completed? _____ years
- How many years of school has your partner completed? _____ years

FAMILY HISTORY

- | 1. | Do you or the father of the baby have any close family members with: | | | |
|-----------------|--|-----------|----------------------------------|-----------|
| | Yes | No | Yes | No |
| diabetes | _____ | _____ | cancer | _____ |
| tuberculosis | _____ | _____ | high blood pressure | _____ |
| heart attack | _____ | _____ | heart problems | _____ |
| twins | _____ | _____ | bleeding problems | _____ |
| cystic fibrosis | _____ | _____ | Down's syndrome | _____ |
| hemophilia | _____ | _____ | mental retardation | _____ |
| spina bifida | _____ | _____ | muscular dystrophy | _____ |
| anencephaly | _____ | _____ | hydrocephalus | _____ |
| incontinence | _____ | _____ | prolapse of vagina/pelvic organs | _____ |

PATIENT IDENTIFICATION

Ten-Point Analog Pain and Urgency Scales

Patient Name _____ Date _____

1. If you have pelvic pain, please circle the number that best describes the **average PELVIC PAIN** (not worst) you have had in the PAST MONTH.

PELVIC PAIN

Mild Moderate Severe (worst ever)

0 1 2 3 4 5 6 7 8 9 10

2. If you have pain associated with your bladder, please circle the number that best describes the **average BLADDER PAIN** (not worst) you have had in the PAST MONTH.

BLADDER PAIN

Mild Moderate Severe (worst ever)

0 1 2 3 4 5 6 7 8 9 10

3. If you have urinary urgency, please circle the number that best describes the **average URINARY PRESSURE or URGENCY** (not worst) you have had in the PAST MONTH.

URINARY URGENCY (pressure to urinate)

Mild Moderate Severe (worst ever)

0 1 2 3 4 5 6 7 8 9 10

PATIENT IDENTIFICATION _____

**PELVIC PAIN and URGENCY/FREQUENCY
PATIENT SYMPTOM SCALE**

Patient's name: _____

Date: _____

PLEASE CIRCLE THE ANSWER THAT BEST DESCRIBES HOW YOU FEEL FOR EACH QUESTION

		0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1	How many times do you void during the waking hours?	3-6	7-10	11-14	15-19	20+		
2	a. How many times do you void at night?	0	1	2	3	4+		
	b. If you get up at night to void, to what extent does it usually bother you?	None	Mild	Moderate	Severe			
3	Are you currently sexually active YES _____ NO _____							
4	a. IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or urgency to urinate during or after sexual intercourse?	Never	Occasionally	Usually	Always			
	b. Has pain or urgency ever made you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5	Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum)?	Never	Occasionally	Usually	Always			
6	Do you still have urgency shortly after urinating?	Never	Occasionally	Usually	Always			
7	a. If you have pain, is it usually		Mild	Moderate	Severe			
	b. How often does your pain bother you?	Never	Occasionally	Usually	Always			
8	a. If you have urgency, is it usually		Mild	Moderate	Severe			
	b. How often does your urgency bother you?	Never	Occasionally	Usually	Always			
							SYMPTOM SCORE (1, 2a, 4a, 5, 6, 7a, 8a)	
							BOTHER SCORE (2b, 4b, 7b, 8b)	
							TOTAL SCORE (Symptom score + Bother Score) =	

PATIENT IDENTIFICATION _____