Endometriosis/Pelvic Pain Questionnaire

Patient Name: _____ **Date:** _____

Pain with Periods

How many days does your period last? _____

How many days is your pain… Severe? _____ Moderate? _____ Mild?_____

How old were you when you started having the pain with periods? _____

Was there ever a time in your life that your periods were NOT as painful? _____

How many days a month do you miss work/school because of the pain with periods? _____

Has your pair gradually worsened overtime or suddenly become worse? _____

How much does the pain associated with periods decrease your ability to function at your normal level? (indicate your typical range below on score)

Can't function at all Decreased by 50% Normal function

Pelvic Pain

Do you have any pelvic or abdominal pain NOT associated with your period? Yes_____ No _____

How many days of the month are you in pain? _____

At what age did you begin to have pelvic pain symptoms? _____

Do you have pain with physical activity? Yes_____ No _____

Please indicate the severity of pain during the month:

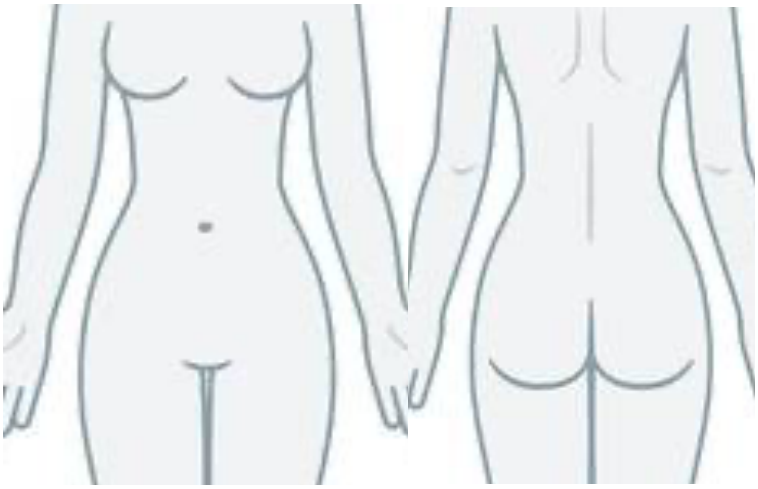
FIRST week AFTER your period: ____None ____Mild ____Moderate ____Severe

With ovulation: ____None ____Mild ____Moderate ____Severe

LAST week BEFORE your period: ____None ____Mild ____Moderate ____Severe

Where is the pain? How would you describe it? (use the key below to mark they type of pain on the diagram)

BURNING	–	**X**
STABBING/SHARP	–	**/**
CRAMPING	–	**O**
THROBBING	–	**#**
ACHING	–	*
PRESSURE	–	Δ



Family and Social History

Do you have any close family members with endometriosis or chronic pain issues?

_____

_____

Do you have any history of physical, sexual or psychological abuse/neglect? Yes_____ No_____
IF you feel comfortable, please describe._____

_____

Pain with sexual intercourse/stimulation

Do you have pain during or after sexual intercourse/stimulation? Yes_____ No _____

When do you experience pain with sexual intercourse/stimulation?

____ Pain with initial entry
____ Pain with deep penetration
____ Pain during orgasm
____ Pain after orgasm
____ I have never achieved orgasm due to pain
____ Pain in specific positions
____ Pain that lingers after intercourse

If you have never been sexually active, can you place a tampon? Yes_____ No _____

Do you have pain with tampon placement? Yes_____ No _____

Urinary symptoms

Do you experience any of the following symptoms? (mark all that apply)

____ Pain with urination
____ Pain with a full bladder
____ Pain after urination
____ Urinary urgency (persistent sensation to urinate)
____ Urinary frequency (urinate more often)
____ Blood in urine

Do your symptoms change during your period? If so, please describe? _____

_____

Bowel symptoms

Do you experience any of the following symptoms? (mark all that apply)

____ Nausea	____ Bloating
____ Vomiting	____ Blood in stool
____ Diarrhea	____ Pain with bowel movements
____ Constipation	____ Rectal pain

Do your symptoms change during your period? If so, please describe? _____

_____

Have you seen a Gastroenterologist or General Surgeon for bowel symptoms? Yes____ No _____
Have you had an Endoscopy or Colonoscopy before? Yes_____ No _____
If so, when and what were the results? _____

_____

Previous Surgeries/Procedures

Surgery	**When**
____ Laparoscopy	_____
____ Open Laparotomy (with larger abdominal incisions)	_____
____ Removal or destruction of endometriosis implants	_____
____ Dilation and Curettage	_____
____ Cesarean Section	_____
____ Ovarian surgery (cyst, torsion)	_____
____ Hydrodistension of the bladder	_____
____ Appendectomy	_____
____ Gall Bladder Removal	_____
____ Upper Endoscopy (EGD)	_____
____ Colonoscopy	_____

Other _____

Previous treatments

Have you tried any of the following for treatments for pain?

____ Non-steroidal anti-inflammatory medications (Ibuprofen, Aleve/Naproxen)
Dose: _____
Improvement: ____None ____A little ____Most of the time ____Complete
____Initial relief but not working anymore

____ Birth control pills/Patch/Ring
Brand name _____
How long were you using the medication? _____
____ Cyclic (you took the placebo pills and had monthly periods)
____ Continuous (bleeding no more than every 3 months, ie: skip placebo pills)
Improvement: ____ None ____A little ____Most of the time ____Complete
____ Initial relief but not working anymore

____ Hormonal Intrauterine device (IUD)
Brand name: Mirena, Kyleena, Liletta, Skyla, Paragard (Non-hormonal)
How long were you using the IUD? _____
Improvement: ____ None ____A little ____Most of the time ____Complete
____ Initial relief but not working anymore

____ Depo Provera
How long were you using it? _____
Improvement: ____ None ____A little ____Most of the time ____Complete
____ Initial relief but not working anymore

____ Lupron (Depo Lupron)
How long were you using it? _____
Improvement: ____ None ____A little ____Most of the time ____Complete
____ Initial relief but not working anymore

____ Orilissa (Elagolix)
Dose: ___ 150mg once a day ____ 200mg twice a day
How long were you using it? _____
Improvement: ____ None ____A little ____Most of the time ____Complete
____ Initial relief but not working anymore

____ Other treatments (Herbal supplements, dietary changes, etc.) please describe:

_____

_____

_____