Oakdale Obstetrics & Gynecology

PATIENT INFORMATION

Contact Numbers:

Home: _____ Cell: _____Work:_____

Which number is best to reach you?_____

How did you learn about our clinic? _____

If referred by a physician, by who and from which healthcare system?

_____

Demographic Information

Ethnicity: _____

Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Committed Relationship

☐ Single ☐ Remarried ☐ Divorced

Who do you live with? _____

Are you currently employed? ☐ Yes ☐ No If yes, ☐ Full-time ☐ Part-time

What kind of work do you do?_____

Information About Your Pain

Please describe your pain problem:

_____

How long have you had this pain?_____

What do you think is causing your pain? _____

What does your family think is causing your pain? _____

Do you think anyone is to blame for your pain? ☐ Yes ☐ No

If so, who?_____

Do you think surgery will be necessary? ☐ Yes ☐ No

Is there an event that you associate with the onset of your pain? ☐ Yes ☐ No

If so, what? _____

Have you missed any work days/school days/family-friend events because of your pain? ☐ Yes ☐ No

If yes, approximately how many days were missed in the last 12 months? _____

PAIN SCALE

For each of the symptoms listed below, check mark (√) your level of pain over the last month using a 10 point scale.

0 = NO PAIN **10 = WORST PAIN IMAGINABLE**

	0	1	2	3	4	5	6	7	8	9	10
Pain at ovulation (mid-cycle)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain level just before period	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain (not cramps) with period	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Deep pain with intercourse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain in groin when lifting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pelvic pain lasting hours or days after intercourse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain when bladder is full	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle/joint pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Level of cramps with period	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain after period is over	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Burning vaginal pain with sex	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain with urination	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Backache	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraine headache	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
What would be an acceptable level of pain?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

What is the worst pain you have ever experienced?

☐ Kidney stone ☐ Bowel obstruction ☐ Migraine headache ☐ Labor & delivery

☐ Current pelvic pain ☐ Backache ☐ Broken bone ☐ Surgery

☐ Other: _____

SHORT-FORM MCGILL QUESTIONNAIRE

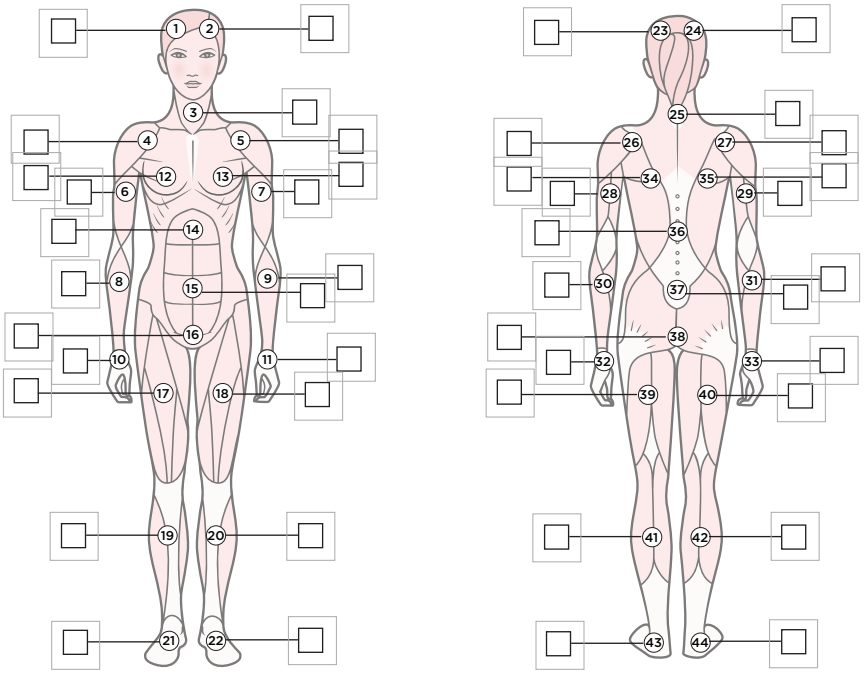
The words below can be used to describe pain. Place a check mark (√) in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of the pain in your pelvic area only.

WHAT DOES YOUR PAIN FEEL LIKE?

Type of Pain	None (0)	Mild (1)	Moderate (2)	Severe (3)
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

PAIN VISUAL

SELECT EACH BOX INDICATING WHERE YOU FEEL INTENSE PAIN.



Lai HH, Jemielita T, Sutcliffe S, Bradley CS, Naliboff B, Williams DA, Gereau RW 4th, Kreder K, Clemens JQ, Rodriguez LV, Krieger JN, Farrar JT, Robinson N, Landis JR; MAPP Research Network. Characterization of Whole Body Pain in Urological Chronic Pelvic Pain Syndrome at Baseline: A MAPP Research Network Study. J Urol. 2017 Sep;198(3):622-631. doi: 10.1016/j.juro.2017.03.132. Epub 2017 Mar 31. PMID: 28373134; PMCID: PMC5562525.

PAIN TREATMENT HISTORY

What types of treatment have you tried in the past for this pain?

- ☐ Acupuncture
- ☐ Anesthesiologist
- ☐ Anti-anxiety
- ☐ Anti-seizure medication
- ☐ Antidepressants
- ☐ Anti-epileptics
- ☐ Biofeedback
- ☐ Birth control pills
- ☐ Danazol (Dancrine)
- ☐ Depo-Provera
- ☐ Family Practitioner
- ☐ Physical Therapy
- ☐ Homeopathic
- ☐ Herbal Medicine
- ☐ Lupron, Zoladex, Synarel
- ☐ Massage
- ☐ Meditation
- ☐ Narcotics
- ☐ Naturopathic medication
- ☐ Nerve Blocks
- ☐ Neurosurgeon
- ☐ Nonprescription medication
- ☐ Nutrition/Diet
- ☐ NSAIDS
- ☐ Psychotherapy
- ☐ Progesterone
- ☐ Rheumatologist
- ☐ Skin Magnets
- ☐ Surgery
- ☐ TENS Unit
- ☐ Trigger Point Injections
- ☐ Other:

_____

☐ Did you have any side effects from hormonal medication?

☐ Yes ☐ No

If yes, please describe:

_____

☐ Of these treatments, is there an option that you felt helped the most?

☐ Yes ☐ No

If yes, please describe:

_____

PAIN TREATMENT HISTORY

What physicians or healthcare providers have evaluated or treated you for pelvic pain? Include all healthcare professionals, whether they were physicians or not.

Physician/Provider	City, State

Do you have any objections to me contacting these providers? ☐ Yes ☐ No

Year	Procedure	Surgeon	Hospital System

Please list pain or hormonal medications you have taken for your condition in the last 6 months, and the physicians who prescribed them for you. You may use a separate page if necessary.

Medication, Dose & Frequency	Now or Past Medication	Physician	Did It Help?

COPING MECHANISMS

Which statement(s) below best describes how you cope with your pain? Check all that apply.

- ☐ I count numbers in my head.
- ☐ I tell myself to be brave and carry on despite the pain.
- ☐ I tell myself that it really doesn't hurt.
- ☐ I just think of it as some other sensation, such as numbness.
- ☐ I pray to God it won't last long.
- ☐ I worry all the time about whether it will end.
- ☐ I do something active, like household chores or projects.
- ☐ I ignore it as best as I can.
- ☐ Other: _____

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

- ☐ Spouse/partner
- ☐ Relative
- ☐ Support group
- ☐ Clergy
- ☐ Friend
- ☐ Doctor/nurse
- ☐ Mental health professional
  If yes, who?
- ☐ I take care of myself

How does your partner deal with your pain?

- ☐ Doesn't notice
- ☐ Takes care of me
- ☐ Withdraws
- ☐ Feels helpless
- ☐ Gets angry
- ☐ Distracts me with activities
- ☐ Not applicable
- ☐ Other:

  _____

What makes your pain worse?

- ☐ Intercourse
- ☐ Orgasm
- ☐ Stress
- ☐ Full meal
- ☐ Bowel movement
- ☐ Full bladder
- ☐ Urination
- ☐ Standing
- ☐ Walking
- ☐ Exercise
- ☐ Time of day
- ☐ Weather
- ☐ Contact with clothing
- ☐ Coughing/Sneezing
- ☐ Not related to anything
- ☐ Other:

  _____

Of all the problems or stressors in your life, how does your pain compare in importance?

- ☐ The most important problem?
- ☐ Just one of the several/many problems

What would you like to tell us about your pain that we have not already asked?

GYNECOLOGICAL HISTORY

Menses

How old were you when your menses (period) started? _____

Are you still having menstrual periods? ☐ Yes ☐ No

Answer the following only if you are still having menstrual periods.

Your periods are: ☐ Light ☐ Moderate ☐ Heavy ☐ Bleed through protection

How many days between your periods? _____ How many days of menstrual flow? _____

Date of last menses? _____ Do you have any pain with your periods? ☐ Yes ☐ No

Does pain start the day flow starts? ☐ Yes ☐ No

Pain starts _____ days before flow starts. ☐ Yes ☐ No

Are your periods regular? ☐ Yes ☐ No

Do you pass any clots in menstrual flow? ☐ Yes ☐ No

Pregnancy History

How many pregnancies have you had? _____

Resulting in (#): ____Full ____Premature ____Abortions ____Miscarriages ____Living children

Any complications during pregnancy, labor, delivery, or postpartum period?

☐ 4° Episiotomy
☐ C-section
☐ Postpartum hemorrhaging
☐ Vaginal lacerations
☐ Forceps
☐ Medication for bleeding
☐ Other: _____

Present Birth Control Method

☐ Nothing
☐ Pill
☐ Vasectomy
☐ Hysterectomy
☐ IUD
☐ Rhythm
☐ Diaphragm
☐ Tubal Ligation
☐ Condoms
☐ Other: _____

Is future fertility desired? ☐ Yes ☐ No

Sexual Functioning

Has your pain interfered with your sexual functioning? ☐ Yes ☐ No

If yes, please describe: _____

Please check the one number that describes how, during the past 24 hours, pain has interfered with your ability to have sexual relations.

0 = DID NOT INTERFERE **10 = COMPLETELY INTERFERED**

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

MEDICAL HISTORY

Who is your Primary Care Provider? _____

What Hospital System? _____ Contact number? _____

Do you have any present medical problems ASIDE form you pelvic pain? ☐ Yes ☐ No

If yes, please list below:

What medications are you presently taking?

Medication	Dose & Frequency		Medication	Dose & Frequency		Medication	Dose & Frequency

Are you allergic to any medications, foods, etc? ☐ Yes ☐ No

If yes, what? _____

Please list all surgeries you have had NOT related to your pelvic pain.

Year	Procedure	Surgeon	Hospital System

Please list any hospitalizations you have had in the past for medical reasons NOT due to surgery or mental health.

Year	Reason	Hospital	Duration

GASTROINTESTINAL/EATING

Do you have nausea? ☐ No ☐ With pain ☐ Taking medications ☐ With eating
☐ Other: _____

Do you have vomiting? ☐ No ☐ With pain ☐ Taking medications ☐ With eating
☐ Other: _____

Have you ever had an eating disorder such as anorexia or bulimia? ☐ Yes ☐ No

Were you treated? ☐ Yes ☐ No

If yes, where and when were you treated? _____

BLADDER FUNCTIONING

IC Symptom Index

During the past month:

How often have you felt the strong need to urinate with no warning?

- ☐ Not at all
- ☐ Less than 1 in 5
- ☐ Less than half the time
- ☐ About half the time
- ☐ More than half the time
- ☐ Almost always

Have you had to urinate less than two hours after you finish urinating?

- ☐ Not at all
- ☐ Less than 1 in 5
- ☐ Less than half the time
- ☐ About half the time
- ☐ More than half the time
- ☐ Almost always

How often did you most typically get up at night to urinate?

- ☐ None
- ☐ Once
- ☐ Two times
- ☐ Three times
- ☐ Four times
- ☐ Five times

Have you experienced pain or burning in your bladder?

- ☐ Not at all
- ☐ A few times
- ☐ Almost always
- ☐ Fairly often
- ☐ Usually

IC Problem Index

During the past month how much has each of the following been a problem for you?

Frequent urination during the day?

- ☐ No problem
- ☐ Very small problem
- ☐ Small problem
- ☐ Medium problem
- ☐ Big problem

Need to urinate with little warning?

- ☐ No problem
- ☐ Very small problem
- ☐ Small problem
- ☐ Medium problem
- ☐ Big problem

Getting up at night to urinate?

- ☐ No problem
- ☐ Very small problem
- ☐ Small problem
- ☐ Medium problem
- ☐ Big problem

Burning, pain, discomfort, or pressure in your bladder?

- ☐ No problem
- ☐ Very small problem
- ☐ Small problem
- ☐ Medium problem
- ☐ Big problem

BOWEL FUNCTIONING

Is there discomfort or pain associated with a change in the consistency of the stool? (i.e. softer or harder)?

☐ Yes ☐ No

Would you say at lease one-fourth of the occasions or days in the last 3 months you have had any of the following? (Check all that apply)

- ☐ Fewer than 3 bowel movements a week (0-2 bowel movements)
- ☐ More than 3 bowel movements a day (4 or more bowel movements)
- ☐ Hard or lumpy stools
- ☐ Loose or watery stools
- ☐ Straining during a bowel movement
- ☐ Urgency – having to rush to the bathroom for a bowel movement
- ☐ Feeling of incomplete emptying after a bowel movement
- ☐ Passing mucus (white material) during a bowel movement
- ☐ Abdominal fullness, bloating, or swelling

HEALTH HABITS

Do you get regular exercise? ☐ Yes ☐ No If yes, what type? _____

What is your diet like? _____

What is your caffeine intake? (Number per day, includes coffee, tea, soft drinks, etc.)

☐ 0 ☐ 1-3 ☐ 4-6 ☐ >6

How many cigarettes do you smoke per day? _____For how long? _____

How often do you drink an alcoholic beverage?

☐ Never ☐ Once per year ☐ Once every couple months ☐ Once every other week
☐ Weekends ☐ 1-2 times per week ☐ 3-4 times per week ☐ Every day

When you do have a drink, how much and what do you drink? _____

Have you ever felt the need to cut down on your drinking? ☐ Yes ☐ No

Have you ever felt annoyed by criticism of your drinking? ☐ Yes ☐ No

Have you ever felt guilty about your drinking or about something you said or did while drinking?

☐ Yes ☐ No

Have you ever taken a morning “eye-opener” drink? ☐ Yes ☐ No

What is your use of recreational drugs?

☐ Never used ☐ Used in past, but not now ☐ Presently using
☐ Prefer not to answer ☐ Marijuana ☐ Cocaine/Crack
☐ Amphetamines ☐ Hallucinogenic ☐ Barbiturates
☐ Other:_____

Have you ever received treatment for substance abuse? ☐ Yes ☐ No

FAMILY HISTORY

Has anyone in your family ever had:

- ☐ fibromyalgia
- ☐ Scleroderma
- ☐ Lupus
- ☐ Irritable bowel syndrome
- ☐ Mental health problems
- ☐ Cancer: If yes, who had it and what type _____
- ☐ Chronic pelvic pain
- ☐ Endometriosis
- ☐ Interstitial cystitis
- ☐ Recurrent urinary tract infection
- ☐ Alcohol or chemical dependency

SEXUAL AND PHYSICAL ABUSE HISTORY

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted.

☐ Yes ☐ No ☐ Prefer not to answer

Please circle an answer for both as a child and as an adult:

	As a child 13 or younger		As an adult 14 or older	
Has anyone ever exposed the sex organs of their body to you when you did not want it?	☐ Yes	☐ No	☐ Yes	☐ No
Has anyone ever threatened to have sex with you when you did not want it?	☐ Yes	☐ No	☐ Yes	☐ No
Has anyone ever touched the sex organs of your body when you did not want this?	☐ Yes	☐ No	☐ Yes	☐ No
Has anyone ever made you touch the sex organs of their body when you did not want this?	☐ Yes	☐ No	☐ Yes	☐ No
Has anyone ever forced you to have sex when you did not want this?	☐ Yes	☐ No	☐ Yes	☐ No
Have you had any other unwanted sexual experience not mentioned above? If yes, please specify below.	☐ Yes	☐ No	☐ Yes	☐ No

When you were a child (13 or younger), did an older person do the following?

Hit, kick or beat you?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often
Seriously threaten your life?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often

Now that you are an adult (14 or older), has any other adult done the following?

Hit, kick or beat you?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often
Seriously threaten your life?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often

COMMENTS

Is there additional information you'd like us to know?

OAKDALE OBGYN
PREMIER WOMEN'S HEALTH
OF MINNESOTA

Maple Grove | Blaine | Plymouth
Early, late, and Saturday appointments | 763-587-7000