

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?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Bowel obstruction | <input type="checkbox"/> Migraine headache | <input type="checkbox"/> Labor & delivery |
| <input type="checkbox"/> Current pelvic pain | <input type="checkbox"/> Backache | <input type="checkbox"/> Broken bone | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Other: _____ | | | |

SHORT-FORM MCGILL QUESTIONNAIRE

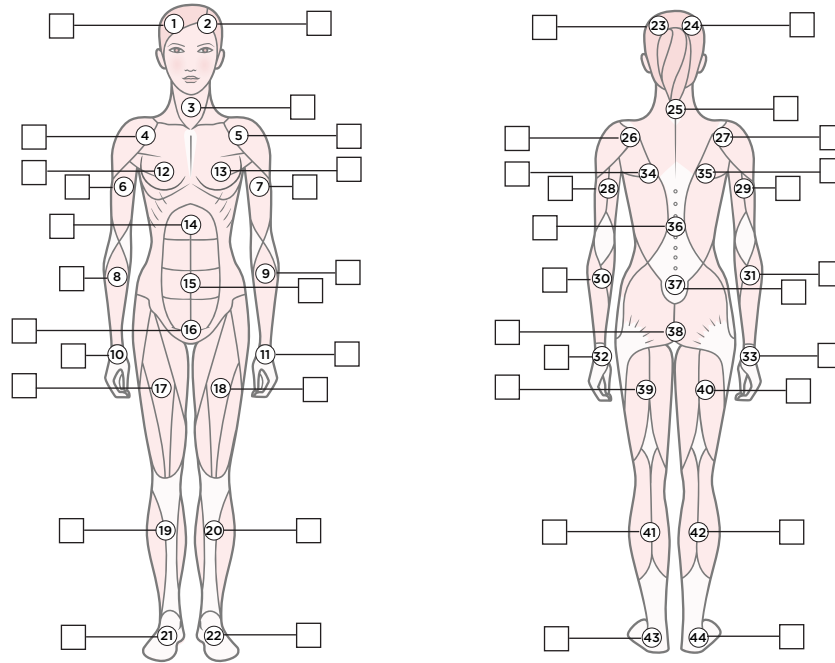
The words below can be used to describe pain. Place a check mark (✓) in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of the pain in your pelvic area only.

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?

- | | | |
|--|---|--|
| <input type="checkbox"/> Acupuncture
<input type="checkbox"/> Anesthesiologist
<input type="checkbox"/> Anti-anxiety
<input type="checkbox"/> Anti-seizure medication
<input type="checkbox"/> Antidepressants
<input type="checkbox"/> Anti-epileptics
<input type="checkbox"/> Biofeedback
<input type="checkbox"/> Birth control pills
<input type="checkbox"/> Danazol (Dancrine)
<input type="checkbox"/> Depo-Provera
<input type="checkbox"/> Family Practitioner
<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Homeopathic
<input type="checkbox"/> Herbal Medicine
<input type="checkbox"/> Lupron, Zoladex, Synarel | <input type="checkbox"/> Massage
<input type="checkbox"/> Meditation
<input type="checkbox"/> Narcotics
<input type="checkbox"/> Naturopathic medication
<input type="checkbox"/> Nerve Blocks
<input type="checkbox"/> Neurosurgeon
<input type="checkbox"/> Nonprescription medication
<input type="checkbox"/> Nutrition/Diet
<input type="checkbox"/> NSAIDS
<input type="checkbox"/> Psychotherapy
<input type="checkbox"/> Progesterone
<input type="checkbox"/> Rheumatologist
<input type="checkbox"/> Skin Magnets
<input type="checkbox"/> Surgery
<input type="checkbox"/> TENS Unit | <input type="checkbox"/> Trigger Point Injections
<input type="checkbox"/> Other:
<hr/> <input type="checkbox"/> Did you have any side effects from hormonal medication?
<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:
<hr/> <input type="checkbox"/> Of these treatments, is there an option that you felt helped the most?
<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:
<hr/> |
|--|---|--|

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.

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

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

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Spouse/partner | <input type="checkbox"/> Clergy | <input type="checkbox"/> Mental health professional |
| <input type="checkbox"/> Relative | <input type="checkbox"/> Friend | If yes, who? |
| <input type="checkbox"/> Support group | <input type="checkbox"/> Doctor/nurse | <input type="checkbox"/> I take care of myself |

How does your partner deal with your pain?

- | | | |
|---|---|---|
| <input type="checkbox"/> Doesn't notice | <input type="checkbox"/> Feels helpless | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Takes care of me | <input type="checkbox"/> Gets angry | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Withdraws | <input type="checkbox"/> Distracts me with activities | _____ |

What makes your pain worse?

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Intercourse | <input type="checkbox"/> Urination | <input type="checkbox"/> Contact with clothing |
| <input type="checkbox"/> Orgasm | <input type="checkbox"/> Standing | <input type="checkbox"/> Coughing/Sneezing |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Walking | <input type="checkbox"/> Not related to anything |
| <input type="checkbox"/> Full meal | <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Bowel movement | <input type="checkbox"/> Time of day | _____ |
| <input type="checkbox"/> Full bladder | <input type="checkbox"/> Weather | |

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?

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> 4° Episiotomy | <input type="checkbox"/> Vaginal lacerations | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Forceps | |
| <input type="checkbox"/> Postpartum hemorrhaging | <input type="checkbox"/> Medication for bleeding | _____ |

Present Birth Control Method

- | | | |
|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> IUD | <input type="checkbox"/> Condoms |
| <input type="checkbox"/> Pill | <input type="checkbox"/> Rhythm | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Diaphragm | |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal Ligation | _____ |

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

Who is your Primary Care Provider? _____

What Hospital System? _____ Contact number? _____

Do you have any present medical problems ASIDE from 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 least one-fourth of the occasions or days in the last 3 months you have had any of the following? (Check all that apply)

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

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:

- | | |
|--|---|
| <input type="checkbox"/> fibromyalgia
<input type="checkbox"/> Scleroderma
<input type="checkbox"/> Lupus
<input type="checkbox"/> Irritable bowel syndrome
<input type="checkbox"/> Mental health problems
<input type="checkbox"/> Cancer: If yes, who had it and what type _____ | <input type="checkbox"/> Chronic pelvic pain
<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Interstitial cystitis
<input type="checkbox"/> Recurrent urinary tract infection
<input type="checkbox"/> 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 <u>child</u> 13 or younger		As an <u>adult</u> 14 or older	
Has anyone ever exposed the sex organs of their body to you when you did not want it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone ever threatened to have sex with you when you did not want it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone ever touched the sex organs of your body when you did not want this?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone ever made you touch the sex organs of their body when you did not want this?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone ever forced you to have sex when you did not want this?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any other unwanted sexual experience not mentioned above? If yes, please specify below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

Hit, kick or beat you?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often
Seriously threaten your life?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often

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

Hit, kick or beat you?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often
Seriously threaten your life?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Occasionally	<input type="checkbox"/> 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

