NorthShore University HealthSystem
Medical Group

Dept. of Obstetrics and Gynecology
Division of Endoscopic Surgery and Chronic Pelvic Pain
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New Patient Intake Questionnaire

Name:
Reason for Referral:
Names & Phone #'s for physicians involved in your care

Referring Physician	Other physician #1	Other physician #2
#(p)	#	#
#(f)_____	#_____	#_____

Questions about the medical condition you are seeing us for

How long has this been going on for?

Describe your symptoms in your own words.

For these questions, please use the back of the sheet(s) if you need more room.

What types of treatments have you tried in the past for this pain? ❑ Acupuncture ❑ Homeopathic medicine ❑ Physical therapy

❑ Anesthesiologist	❑ Lupron, Zoladex, Synarel	❑ Psychotherapy
❑ Anti-seizure medications	❑ Massage	❑ Rheumatologist
❑ Antidepressants	❑ Meditation	❑ Skin magnets
❑ Biofeedback	❑ Narcotics	❑ Surgery
❑ Birth control pills	❑ Naturopathic medications	❑ TENS unit
❑ Danazol (Danocrine)	❑ Nerve blocks	❑ Trigger point injections
❑ Depo-Provera	❑ Neurosurgeon	❑ Other _____
❑ Family Practitioner	❑ Nonprescription medicine	
❑ Herbal medication	❑ Nutrition/diet	

What operations have been tried before, and how long were they effective?

For each pain medications that was tried, how long was it effective?

*If you are being referred for a pain problem, please also answer these questions

Please describe any history of depression, anxiety, or other mood disorders. Please explain any history of headaches or other pain problems. Please explain any problems related to overuse of pain killers?

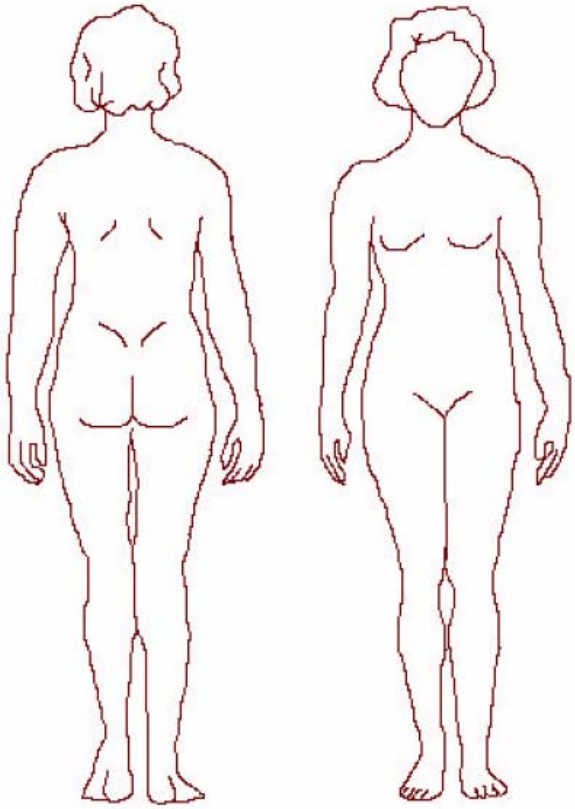
General questions about your health

Do you have any problems with getting a good night's sleep? Please explain if yes.

Do you have any problems with urination (pain, frequency, urgency?)

Do you have any problems with bowel movements (pain, constipation?)

How often do you exercise a week? What forms of exercise, and how many minutes each time?



Place an "X" at the point of your most intense pain.
Shade in all other painful areas.

Please list below all other current medical conditions or previous surgeries (continue on back of sheet if needed)

Medical Conditions	Surgeries (Date, Surgeon)

General questions about previous gynecological issues

Menses

How old were you when your menses started? _____

Are you still having menstrual periods? ❑ Yes ❑ No

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

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

Starts _____ days before flow starts: ❑ Yes ❑ No

Are periods regular? ❑ Yes ❑ No

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

How many days are painful?

Describe the discomfort of your monthly cycle (circle one): None mild moderate severe

When was your last Pap smear?

Have you ever had an abnormal Pap smear, and if so, what type of problem? When was it?

Have you ever been diagnosed with a pelvic infection and if so, what type of infection?

How many pregnancies have you had, and how many living children?

Are you currently sexually active?

Is/are your partner(s) female, male, or both?

How frequently are you sexually active?

Do you have any pain or other problems related to intercourse?

SF-12

Directions: This survey asks for your view about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:	Excellent □	Very Good □	Good □	Fair □	Poor □
2. The following questions are about activities you might do during a typical day. Does <u>your health now limit</u> you in these activities? If so, how much?	Yes, limited a lot	Yes, limited a little	No, Not limited at all		
a) <u>Moderate activities</u>, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	□	□	□		
b) Climbing <u>several</u> flights of stairs	□	□	□		
3. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a) <u>Accomplished less</u> that you would like	□	□	□	□	□
b) Were limited in the <u>kind</u> of work or other activities	□	□	□	□	□
4. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a) <u>Accomplished less</u> than you would like	□	□	□	□	□
b) Did work or activities <u>less carefully than usual</u>	□	□	□	□	□
5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?	Not at all □	A little bit □	Moderately □	Quite a bit □	Extremely □
6.These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a) Have you felt calm and peaceful?	□	□	□	□	□
b) Did you have a lot of energy?	□	□	□	□	□
c) Have you felt downhearted and depressed?	□	□	□	□	□
7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	All of the time □	Most of the time □	Some of the time □	A little of the time □	None of the time □
Thank You for completing these questions!					

PAIN

How many **years** have you had chronic pelvic pain? _____(years)

The words below describe the types of *pelvic pain* that some people experience. Circle the column that represents the degree to which you have been feeling each type of pain during the ***past two weeks***.

	None	Mild	Moderate	Severe
1) Throbbing	0	1	2	3
2) Shooting	0	1	2	3
3) Stabbing	0	1	2	3
4) Sharp	0	1	2	3
5) Cramping	0	1	2	3
6) Gnawing	0	1	2	3
7) Hot-Burning	0	1	2	3
8) Aching	0	1	2	3
9) Heavy	0	1	2	3
10) Tender	0	1	2	3
11) Splitting	0	1	2	3
12) Tiring-Exhausting	0	1	2	3
13) Sickening	0	1	2	3
14) Fearful	0	1	2	3
15) Punishing-Cruel	0	1	2	3

16) Circle the number below that indicates your overall pain intensity ***during the past two weeks***.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

17) Circle the number that indicates your overall ***pelvic pain*** intensity ***during the past two weeks***.

0) No pain
1) Mild
2) Discomforting
3) Distressing
4) Horrible
5) Excruciating

CSQ

Persons who experience pain have developed a number of ways to cope or deal with it. Below is a list of thoughts or feelings that some patients have when they experience pain or medical symptoms. For each thought or feeling below, *please indicate how often you feel this way when you experience pain* using the scale from 0 (never think or feel that way) to 6 (always think or feel that way). *Remember you can use any point along the scale from 0 to 6.*

When I feel pain …	Never think or feel that			Sometimes think or feel that			Always think or feel that
1. It is terrible and I feel it's never going to get any better.	0	1	2	3	4	5	6
2. It is awful and I feel that it overwhelms me.	0	1	2	3	4	5	6
3. I feel my life isn't worth living.	0	1	2	3	4	5	6
4. I worry all the time about whether it will end.	0	1	2	3	4	5	6
5. I feel I can't stand it anymore.	0	1	2	3	4	5	6
6. I feel like I can't go on.	0	1	2	3	4	5	6

	No control			Some control			Complete control
7. Based on all the things you do to cope or deal with your pain and symptoms, on an average day, *how much control do you feel you have over it?*	0	1	2	3	4	5	6

	Can't decrease it at all			Can decrease it somewhat			Can decrease it completely
8. Based on all the things you do to cope or deal with your pain and symptoms, on an average day, *how much are you able to decrease it?*	0	1	2	3	4	5	6