NorthShore University HealthSystem

Dept. of Obstetrics and Gynecology
Division of Gynecological Pain and Minimally Invasive Surgery
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Medical Group

New Patient Intake Questionnaire

Name:

Names & Phone #'s for physicians involved in your care

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

In brief, what is the main reason you are seeing the doctor today:_____

How long have you had the symptoms?
_____6mo or less _____6mo-1 year _____ 1-2 years _____3-5 years _____6-10 years _____>10years

What prior treatments have you tried? (Circle all that apply)
Bladder medication, Kegel exercises, Physical Therapy
Medication for pelvic or vaginal pain, UFE, NSAIDS, Opioids, Birth control pills/hormonal treatments, IUD, Lupron, Antidepressant medications, Antiseizure medications, Acupuncture, Compounded drugs/topical drugs, Antibiotics, Nerve blocks, Other _____

What are your goals for seeing the doctor?

Decrease urination at day or night		Improve bleeding	
Reduce urinary tract infections		Treat fibroids	
Improve my bowel habits		Optimize fertility	
Improve sexual function		Treat ovarian cyst	
Reduce pain		Other	

How often are you urinating (# hours between daytime voids)_____

Fertility Questions

Number of Pregnancies	
Number of Deliveries	
Are you currently trying to conceive?	
Are you currently undergoing fertility treatment?	
Do you have a desire for future fertility?	

Menstrual History

Have you had a menstrual period in the last 6 months? (circle one)
YES NO
Are menstrual periods regular? (circle one)
YES NO
What is the average length of your menses? _____
(from the 1st day of your cycle to the 1st day of the next cycle)
What is the average number of days you bleed with each period? _____
How heavy is your period? (circle one)
very (changing a pad/tampon in less than 2 hours)
moderate (changing a pad/tampon every 2-4 hours);
mild (using 1-3 pads/tampons a day)
Do you have bleeding between your periods? (circle one)
YES NO
How much pain/cramping do you have with your menstrual period? (0-10) _____
Does your menstrual pain limit your daily activities? (circle one)
YES NO
Do you take pain medication regularly for menstrual pain? (circle one)
YES NO

Medical Conditions			Surgeries (Date, Surgeon)
List all medical conditions			
Do you have the any of the following?			
Fibromyalgia	Yes	No	
Chronic Fatigue Syndrome	Yes	No	
Interstitial Cystitis	Yes	No	
Irritable Bowel Syndrome	Yes	No	
Low Back Pain	Yes	No	
Chronic Headaches	Yes	No	
TMJ (temporomandibular joint disorder)	Yes	No	

MEDICATIONS - current	FAMILY HISTORY
	Please indicate if any members have the following: (and list who they are – ex. maternal grandmother) Breast cancer Colon cancer Ovarian cancer Easy bleeding problems Blood clotting issues

REVIEW OF SYSTEMS: Please mark any symptoms that you have experienced in the last 3 months.

□ *check this box if you do NOT have any of these symptoms*

General	√ = yes	Gastrointestinal	√ = yes
Chronic fatigue		Nausea or vomiting	
Fevers		Poor appetite	
Difficulty falling or staying asleep		Abdominal bloating/fullness	
Unintentional weight loss		Heartburn	
Unintentional weight gain		Constipation	
Skin		Diarrhea	
Rash		Blood in stools	
Itching		Pain with bowel movements	
Vaginal / vulvar ulcers or fissures		**Urinary**	
Head and Neck		Frequent urination (>8 times/day)	
Itchy eyes		Urgency (sudden urge to urinate)	
Sore throat		Urine leaking	
Mouth sores or ulcers		Pain with urination	
Bleeding gums		Blood in urine	
Heart		Incomplete bladder emptying	
Chest pain		Night time urination (>2 /night)	
Irregular heart beat		**Musculoskeletal**	
Ankle/foot swelling		Muscle or joint pain	
Lungs		Body aches or stiffness	
Shortness of breath		Leg pain	
Chronic cough		Back pain	
Wheezing		**Neurologic**	
Endocrine		Headaches	
Excess hair growth		Dizziness	
Nipple discharge		Memory Loss	
Hot flashes		Low attention	

Some women experience pain during the following times or with certain activities. Please rate the severity of pain that you experience during these times by marking ONE box for each activity. *Please answer all questions*

"0" indicates no pain at all, "10" indicates pain as bad as you can imagine.

	0=no pain					10=pain as bad as you can imagine					
	0	1	2	3	4	5	6	7	8	9	10
Pain with urination	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain with full bladder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain with bowel movements	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Deep pain with intercourse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain with entry during intercourse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain with tampon insertion	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Overall pain intensity during the past week (circle one)
No pain Mild pain Discomforting pain Distressing pain Horrible pain Excruciating pain

McGill Pain Inventory

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

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

Voiding and pain indices

Interstitial Cystitis Symptom Index (ICSI)	**Interstitial Cystitis Problem Index (ICPI)**
Q1. *During the past month*, how often have You felt the strong need to urinate with little Or no warning? 0.___not at all 1.___less than 1 time in 5 2.___less than half the time 3.___about half the time 4.___more than half the time 5.___almost always	*During the past month*, how much has each of the Following been a problem for you? Q1. Frequent urination during the day? 0.____no problem 1.____very small problem 2.____small problem 3.____medium problem 4.____big problem
Q2. *During the past month*, have you had to urinate Less than 2 hours after you finished urinating? 0.___not at all 1.___less than 1 time in 5 2.___less than half the time 3.___about half the time 4.___more than half the time 5.___almost always	Q2. Getting up at night to urinate? 0.____no problem 1.____very small problem 2.____small problem 3.____medium problem 4.____big problem
Q3. *During the past month*, how often did you most Typically get up at night to urinate? 0.___none 1.___once 2.___2 times 3.___3 times 4.___4 times 5.___5 or more times	Q3. Need to urinate with little warning? 0.____no problem 1.____very small problem 2.____small problem 3.____medium problem 4.____big problem
Q4. *During the past month*, have you experienced Pain or burning in your bladder? 0.___not at all 1.___a few times 2.___almost always 3.___fairly often 4.___usually Add the numerical values of the checked entries; Total score:_____.	Q4. Burning, pain, discomfort, or pressure in your Bladder? 0.____no problem 1.____very small problem 2.____small problem 3.____medium problem 4.____big problem Add the numerical values of the checked entries: Total Score:_____.

Please respond to each question by marking one box per row

Promis Short From – Fatigue

In the past 7 days …

	Never	Rarely	Sometimes	Often	Always
How often do you feel tired?	1	2	3	4	5
How often did you experience extreme exhaustion?	1	2	3	4	5
How often did you run out of energy?	1	2	3	4	5
How often did your fatigue limit you at work (include work at home)?	1	2	3	4	5
How often were you too tired to think clearly?	1	2	3	4	5
How often were you too tired to take a bath or shower?	1	2	3	4	5
How often did you have enough energy to exercise strenuously?	5	4	3	2	1

Promis Short From – Emotional Distress- Depression

In the past 7 days …

	Never	Rarely	Sometimes	Often	Always
I felt worthless	1	2	3	4	5
I felt that I had nothing to look forward to	1	2	3	4	5
I felt helpless	1	2	3	4	5
I felt sad	1	2	3	4	5
I felt like a failure	1	2	3	4	5
I felt depressed	1	2	3	4	5
I felt unhappy	1	2	3	4	5
I felt hopeless	1	2	3	4	5

Promis Short From – Emotional Distress- Anxiety

In the past 7 days …

	Never	Rarely	Sometimes	Often	Always
I felt fearful	1	2	3	4	5
I felt anxious	1	2	3	4	5
I felt worried	1	2	3	4	5
I found it hard to focus on anything other than my anxiety	1	2	3	4	5
I felt nervous	1	2	3	4	5
I felt uneasy	1	2	3	4	5
I felt tense	1	2	3	4	5

Promis Short From – Pain Behavior

In the past 7 days …

	Had no pain	Never	Rarely	Sometimes	Often	Always
When I was in pain I became irritable	1	2	3	4	5	6
When I was in pain I grimaced	1	2	3	4	5	6
When I was in pain I would lie down	1	2	3	4	5	6
When I was in pain I moved extremely slowly	1	2	3	4	5	6
When I was in pain I became angry	1	2	3	4	5	6
When I was in pain I clenched my teeth	1	2	3	4	5	6
When I was in pain I tried to stay very still	1	2	3	4	5	6
When I was in pain I appeared upset or sad	1	2	3	4	5	6
When I was in pain I gasped	1	2	3	4	5	6

Promis Short From – Pain Interference

In the past 7 days …

	Not at all	A little bit	Somewhat	Quite a bit	Very much
How much did pain interfere with your enjoyment of life?	1	2	3	4	5
How much did pain interfere with your ability to concentrate?	1	2	3	4	5
How much did pain interfere with your day to day activities?	1	2	3	4	5
How much did pain interfere with your enjoyment of recreational activities?	1	2	3	4	5
How much did pain interfere with your tasks away from home (e.g. getting groceries, running errands)?	1	2	3	4	5

In the past 7 days …

	Never	Rarely	Sometimes	Often	Always
How often did pain keep you from socializing with others?	1	2	3	4	5

Promis Short From – Physical Functioning

In the past 7 days …

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to stand for one hour?	5	4	3	2	1
Are you able to do chores such as vacuuming or yard work?	5	4	3	2	1
Are you able to push open a heavy door?	5	4	3	2	1
Are you able to exercise for an hour?	5	4	3	2	1
Are you able to carry a heavy object (over 10 pounds)?	5	4	3	2	1
Are you able to stand up from an armless straight chair?	5	4	3	2	1
Are you able to dress yourself, including tying shoelaces and doing buttons?	5	4	3	2	1
Are you able to reach into a high cupboard?	5	4	3	2	1