CENTER FOR CHRONICAL PELVIC PAIN

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PRE-CONSULTATION QUESTIONNAIRE FOR PERINEAL PAIN

DATE:.....

1 – GENERAL INFORMATION

Surname:..... First name:.....

Date of birth: ..... Telephone: .....

Occupation: ..... Height: ..... Weight: .....

Address: .....

Regular Doctor:

Surname: Telephone: .....

Address: .....

Specialist(s):

Surname(1) .....Specialism: .....

Address: .....

Surname(2) .....Specialism: .....

Address: .....

Surname(3) .....Specialism: .....

Address: .....

2 – BACKGROUND:

***a) -* Medical history**:

Tick the illnesses you have had now or in the past:

☐ Diabetes ☐ Depression

☐ High blood pressure ☐ Peptic ulcers

☐ Cardiac disease ☐ Cancer

☐ Allergies ☐ Anticoagulants / Aspirin

☐ Others: please note: (*: (Including algodystrophy, lumbago, migraines, fibrositis)*

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***b) -* Previous surgery**: urological*, gynaecological, gastrointestinal, or colorectal?*

If yes, please note which intervention(s) and when they were performed

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c) - Maternity: (for women only)

- Childbirth? ☐ YES ☐ NO

- Date: .....
- If yes:
  - how many times?.....
  - natural childbirth? ☐ YES ☐ NO
  - episotomy? ☐ YES ☐ NO
  - assisted with vacuum extraction, forceps? ☐ YES ☐ NO
- Miscarriage? ☐ YES ☐ NO
- Abortion? ☐ YES ☐ NO

d).....

enstrual cycle, Sexuality and Contraception: *women only*

- ***Sexuality***: intercourse? ☐ YES ☐ NO
- If yes, does it cause pain? ☐ YES ☐ NO
- does the pain affect your Sexual Activity? ☐ YES ☐ NO
- ***Periods***: date of your 1st period:.....
- Painful periods? ☐ YES ☐ NO
- Regular periods? ☐ YES ☐ NO
- Does your pain get worse depending on your menstrual cycle? ☐ YES ☐ NO
- ***Oral contraceptives***: ☐ YES ☐ NO
- Do you feel better when you take oral contraceptives? ☐ YES ☐ NO

3 - PAIN BACKGROUND:

a).....**O**

nset:

- ✓ When did it start? .....
- ✓ Abruptly ☐ Gradually ☐
- ✓ Following a triggering event? ☐ If yes, what was it? .....

b) **How the pain evolves:**

Stable?	☐	Getting worse?	☐
Getting better?	☐	Variable?	☐
Does it occur every day?	☐ YES	☐ NO	

4- INTENSITY OF THE PAIN :

Give a score from 0 to 10, to indicate how intense your pain is (0 = no pain, 10 = maximum pain imaginable)

- **Please note the highest level of pain over the last 15 days: I___I**

- **Please note the highest level of pain over the last 15 days: I___I**

- **Changes:**
  - ✓ Positions and circumstances that change the pain you feel:

Aggravate the pain (or trigger it): ***A***

Diminish the pain: ***D***

Neutral: ***N***

Sitting	Standing	Walking	Lying down	Urination	Defecation	Contact (underwear)	Sexual Intercourse

Getting up	Early morning	Late afternoon	Afternoon	Evening	Night (woken up by pain)

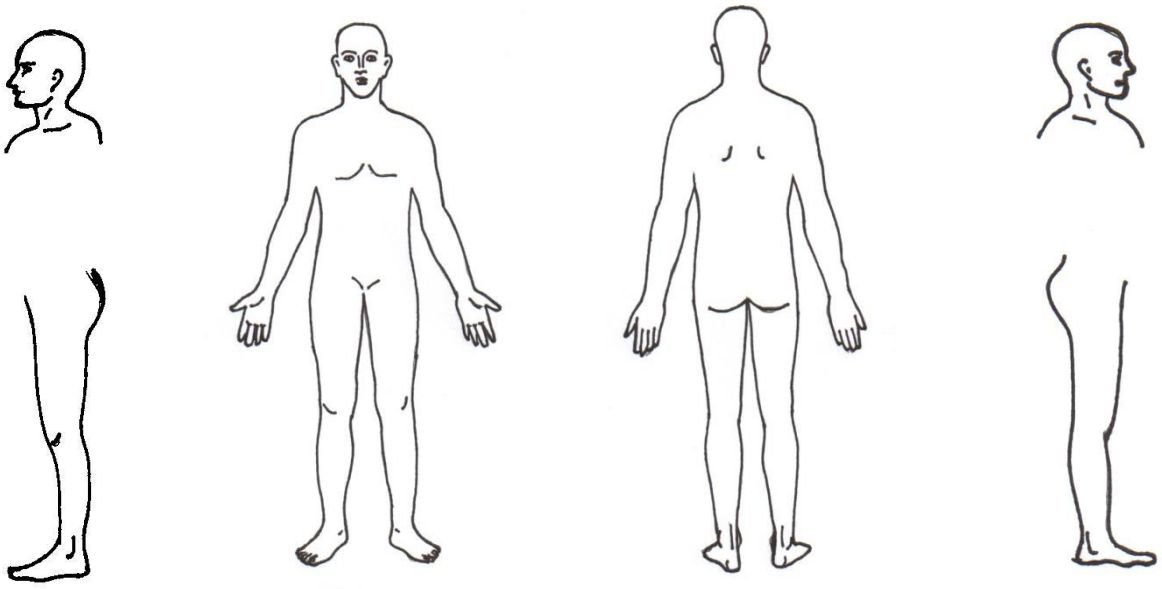
Before your period	After your period	During your period	Mid-cycle	Oral contraceptives

- **How long can you sit in a normal way (minutes): T: _____ min**

- **How does it take the pain to start when you sit (minutes): T : _____ min**

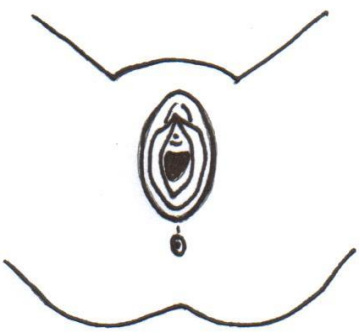
- **In order to sit down, do you have to use special techniques (one buttock only, bolster, cushion)?**

5 - LOCATION OF THE PAIN:

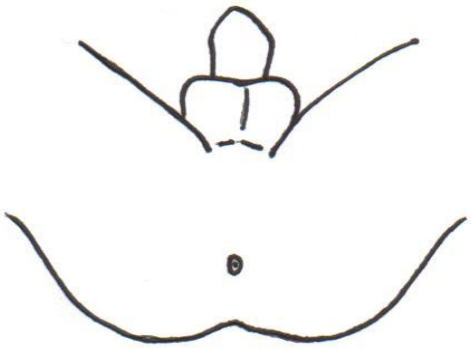


Women:

Men:



RIGHT T



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6 – DESCRIPTION OF THE PAIN

Fill in the 2 following questionnaires:

➢ First questionnaire: in order to identify the pain that you feel in general, circle the best words to describe your pain (no more than one word per paragraph) and give a score from 0 to 4 using the table below.

0 : NONE OR NOT AT ALL
1: WEAK OR A LITTLE
2: MEDIUM OR MODERATELY
3: STRONG OR A LOT
4: EXTREME OR EXTREMELY STRONG

A	BEATING		E	SHARP TUGGING		K	NAUSEATING	
	PULSATING			STRETCHING			SUFFOCATING	
	SHOOTING			DISTENSION			FAINTING	
	FLASHING			RIPPING		L	UNSETTLING	
	ELECTRIC SHOCK			TWISTING			OPPRESSIVE	
				PULLING			DISTRESSING	
	HAMMER BLOWS							
B	GLOWING		F	HEAT		M	TORMENTING	
	RADIATING			BURNING			BOTHERSOME	
C	PRICKING		G	COLD			CRUEL	
	CUTTING			ICE			TORTIOUS	
	PENETRATING		H	TINGLING			AGONISING	
	PIERCING			PINS AND NEEDLES		N	UNCOMFORTABLE	
	STABBING			ITCHING			UNPLEASANT	
D	PINCHING		I	NUMBNESS			GRUELLING	
	TIGHTNESS			HEAVINESS			UNBEARABLE	
	COMPRESSION			MUFFLED		O	ANNOYING	
	CRUSHING		J	TIRING			EXASPERATING	
	CLAMPING			EXHAUSTING			INFRURIATING	
	GRINDING			BACK-BREAKING		P	DEPRESSING	
							SUICIDAL	

➢ SECOND QUESTIONNAIRE:·

Burning	Pricking	Numbness	Tingling	Foreign body	Electric shock	Itching

7 - RELATED PROBLEMS and EFFECTS

✓ Urinary **problems**? yes ☐ no ☐

If yes, what kind? .....

✓ Digestive **problems**? yes ☐ no ☐

If yes, what kind? .....

✓ Colorectal **problems**? yes ☐ no ☐

If yes, what kind (defecation)?.....

➢ **Impact on your daily life**

Give a score from 0 to 10, to indicate the level of impact your pain has
(0 = no impact, 10 = major impact)

○ **Mood**: I_____I

○ **Ability to walk**: I_____I

○ **Regular work**: I_____I (including outside the home as well as work around the house)

○ **Relationships with others**: I_____I

○ **Sleep** : I_____I Sleep time: ……hours per day

Refreshing sleep: YES ☐ NO ☐

○ **Appetite for life**: I_____I

○ **Sex life**: I_____I

8 - OTHER TESTS PERFORMED:

Examinations:	What were they? Which part of the body?

MRI ☐ Scanner ☐ Electromyography ▪ ▪ ☐ Colonoscopy ☐ Scintigraphy (gamma scan) Other ☐	

9– TREATMENT USING MEDICATION:

- *CURRENT*:

Name	Dose	Date of first treatment	Effectiveness	Tolerance

- *TREATMENTS ATTEMPTED*:

Name	Dose	Date of first treatment	Effectiveness	Tolerance

10– <u>OTHER TREATMENT</u>:

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HAVE YOU PREVIOUSLY HAD INJECTIONS IN THE PUDENDAL NERVE?:

☐ YES ☐ NO

If yes, please give a date: .....

Direct effect? ☐ YES .....☐ NO

Effective elsewhere? ☐ YES.....☐ NO

COMMENTS AND REMARKS:

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