UB|MD OBSTETRICS & GYNECOLOGY

Name: _____ Date: _____

Referring Provider's Name and Address:

_____

Chief Concern for Today's Visit:

_____

_____

_____

_____

_____

How long have you had these symptoms? _____

What do you think is causing your symptoms?

_____

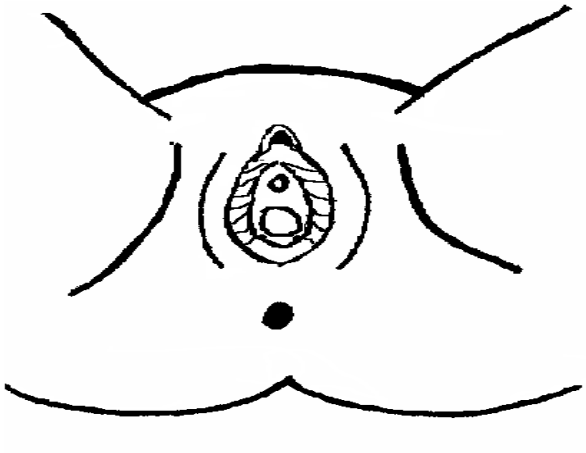
Is there an event that you associate with the onset of your pain? □ Yes □ No

If so, what? _____

_____

Pain Map:

Please shade areas of pain and write a number from 1 to 10 at the site of pain, (10 = worst pain imaginable).



Pain Dairy:

For each of the symptoms listed below, please check 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 just before your period											
Deep pain with intercourse											
Pain in groin with lifting											
Pelvic pain lasting hours/days after sexual intercourse											
Pain with full bladder											
Muscle/joint pain											
Cramps with menstrual period											
Pain after menstrual period is over											
Burning vaginal pain after sex											
Pain with urination											
Backache											
Migraine headache											
Pain with sitting											

Demographic Information:

Are you (check all that apply):
☐ Married ☐ Widowed ☐ Separated ☐ Committed Relationship
☐ Single ☐ Remarried ☐ Divorced
Who do you live with?

_____

Education: ☐ Fewer than 12 years ☐ High School graduate
☐ College degree ☐ Postgraduate degree

What type of work are you trained for?

_____

What type of work are you doing?

_____

Obstetrical History

How many pregnancies have you had? _____
Resulting in (#): _____ Full 9 months _____ Premature _____ Miscarriage / Abortion _____ Living children
Were there any complications during pregnancy, labor, delivery, or postpartum?
☐ 4° Episiotomy ☐ C-Section ☐ Vacuum ☐ Post-partum hemorrhage
☐ Vaginal laceration ☐ Forceps ☐ Medication for bleeding ☐ Other _____

Health Habits:

How often do you exercise?
☐ Rarely ☐ 1-2 times weekly ☐ 3-5 times weekly ☐ Daily
What is your caffeine intake (number cups per day, coffee, tea, soft drinks, etc)?
☐ 0 ☐ 1-3 ☐ 4-6 ☐ >6
How many cigarettes do you smoke per day? _____ For how many years? _____
Do you drink alcohol? ☐ Yes ☐ No
Number of drinks per week _____
Have you ever received treatment for substance abuse? ☐ Yes ☐ No
What is your use of recreational drugs? ☐ Never used ☐ Used in the past, but not now ☐ Presently using ☐ No answer
☐ Heroin ☐ Amphetamines ☐ Marijuana ☐ Barbiturates ☐ Cocaine ☐ Other _____
How would you describe your diet? (check all that apply)
☐ Well-balanced ☐ Vegan ☐ Vegetarian ☐ Fried food
☐ Special diet _____ ☐Other _____

Medical History:

	You	Family Member (specify)
Fibromyalgia		
Depression		
Chronic Pelvic Pain		
Interstitial Cystitis		
Endometriosis		
Irritable Bowel Syndrome		
TMJ		
Other Chronic Condition		

Please list all other **Medical Problems**/**Diagnoses**:
_____
_____
_____
_____

Allergies (including latex allergy):
_____
Who is your primary care provider?
_____
Have you ever been hospitalized for anything besides childbirth? ☐ Yes ☐ No
If yes, please explain:
_____
_____
Have you had major accidents such as falls or a back injury? ☐ Yes ☐ No
Have you ever been treated for depression? ☐ Yes ☐ No
Treatments: ☐ Medication ☐ Hospitalization ☐ Psychotherapy
Birth control method: ☐ Nothing ☐ Pill ☐ Vasectomy ☐ Vaginal ring ☐ Depo-provera ☐ Condom ☐ IUD ☐ Hysterectomy ☐ Diaphragm ☐ Tubal Sterilization
□ Other _____

Please list all treatments you have had for your condition, including prescribed medications, over the counter medications and surgical treatments, when you tried each treatment, and if the treatment was of benefit:

Treatment	Year	Benefit?

Sexual and Physical Abuse History	As a Child (< 13)		As an Adult (> 14)	
	Yes	No	Yes	No
Have you ever been the victim of emotional abuse?				
Has anyone ever exposed their sex organs to you against your will?				
Has anyone ever threatened to have sex with you against your will?				
Has anyone ever touched your sex organs against your will?				
Has anyone ever made you touch their sex organs against your will?				
Has anyone forced you to have sex against your will?				
Have you had other unwanted sexual experiences? If yes, please specify below:				

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

Please Circle Best Answer for					
Bladder Function Questions	0	1	2	3	4
How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20 or more
How many times do you go to the bathroom at night?	0	1	2	3	4 or more
Does it bother you if you get up to void (empty your bladder) at night?	Never	Mildly	Moderately	Severely	
Do you have urgency after voiding?	Never	Occasionally	Usually	Always	
If you have urgency, is it usually?	Never	Mild	Moderate	Severe	
Does your urgency bother you?	Never	Occasionally	Usually	Always	
Do you have pain associated with your bladder or in your pelvis?	Never	Occasionally	Usually	Always	
If you have pain, is it usually?	Never	Mild	Moderate	Severe	
Does your pain bother you?	Never	Occasionally	Usually	Always	

The Female Sexual Distress Scale-Revised (FSDS-R; revised 2005)

Below is a list of feelings and problems that women sometimes have concerning their sexuality. Please read each item carefully, and check the box that corresponds with the number that best describes **HOW OFTEN THAT PROBLEM HAS BOTHERED YOU OR CAUSED YOU DISTRESS DURING THE PAST 30 DAYS INCLUDING TODAY**.

NEVER, 0 RARELY, 1 OCCASIONALLY, 2 FREQUENTLY, 3 ALWAYS, 4

* DeRogatis L, et al. *J Sex Med*. 2008;5:357-364.

	0	1	2	3	4
Distressed about your sex life					
Unhappy about your sexual relationship					
Guilty about sexual difficulties					
Frustrated by your sexual problems					
Stressed about sex					
Feel inferior because of sexual problems					
Worried about sex					
Feel sexually inadequate					
Regrets about your sexuality					
Embarrassed about your sexual problems					
Dissatisfied with your sex life					
Angry about your sex life					
Bothered by low sexual desire					