CRRS NEW PATIENT QUESTIONNAIRE

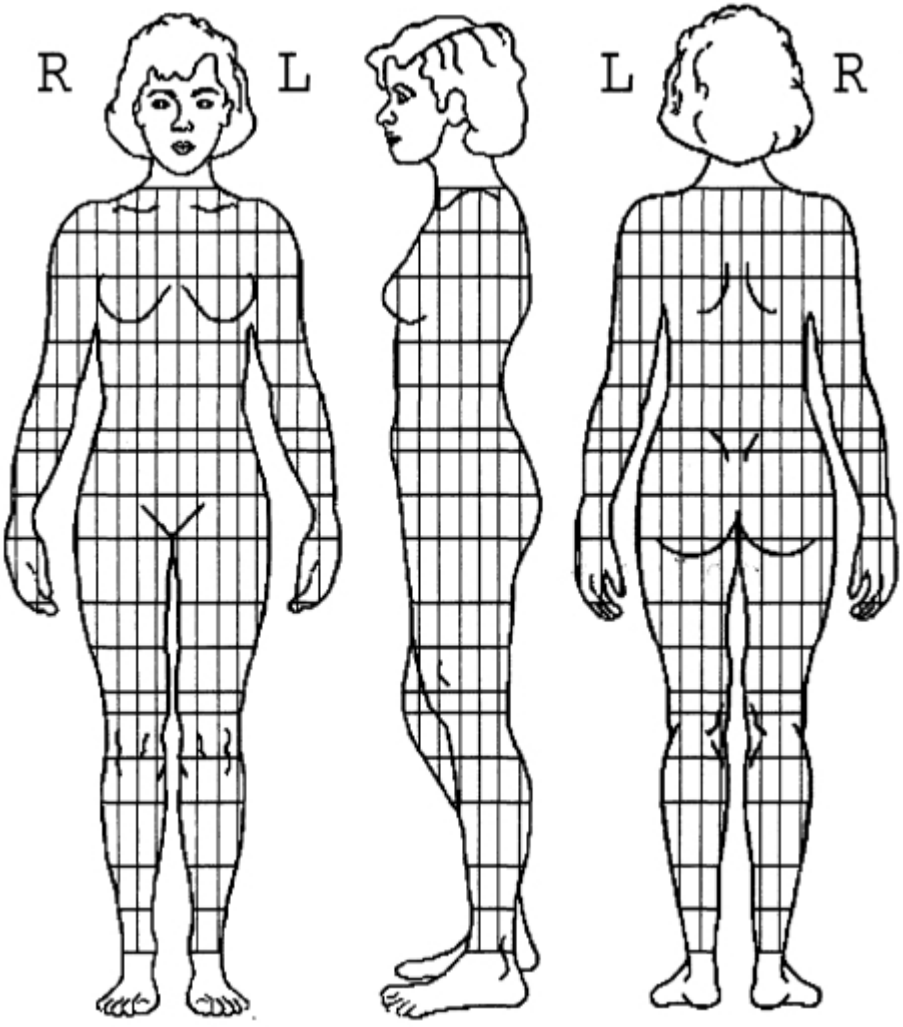
Name:	DOB:	Date:	Height:	Weight:

Modified International Pelvic Pain Society Questionnaire (Scale: 0-no pain, 10-worst pain imaginable)											
Overall pain	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain (not cramps) before period	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Ovulation (mid-cycle) pain	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain just before period	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Period cramps	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain after period is over	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain in groin when lifting	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain with insertion during intercourse	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Deep pain with intercourse	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pelvic pain lasting for hours/days after intercourse	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain when bladder is full	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain with urination	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain right after urination	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain at the flank / Kidney	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Lower back pain	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Muscle or joint pain	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain with bowel movement	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Severity of constipation	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Severity of diarrhea	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Severity of bloating	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Severity of intestinal cramping	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain with sitting	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain on neck / shoulders	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain underneath ribs	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

More Information about your pain			
What type of treatments or providers have you tried in the past for your pain? *(Please check all that apply)*			
☐ Acupuncture	☐ Anesthesiologist	☐ Anti-seizure medications	☐ Biofeedback
☐ Botox injection	☐ Contraceptive pills / ring / patch	☐ Danazol (Danocrine)	☐ Depo-provera
☐ Gastroenterologist	☐ Gynecologist	☐ Family Practitioner	☐ Herbal Medicine
☐ Homeopathic Medicine	☐ Lupron, Synarel, Zoladex, e.t.c	☐ Massage	☐ Meditation
☐ Narcotics	☐ Naturopathic medication	☐ Nerve blocks	☐ Neurosurgeon
☐ Non-prescription medicine	☐ Nutrition / Diet	☐ Physical Therapy	☐ Psychological Counsellor
☐ Psychiatrist	☐ Rheumatologist	☐ Skin magnets	☐ Surgery
☐ TENS unit	☐ Trigger point injections	☐ Urologist	☐ Letrozole (Femara)
☐ Others:			

Pain Maps

Please shade **all** areas of pain. Indicate with a star ★ the area where you experience the most pain

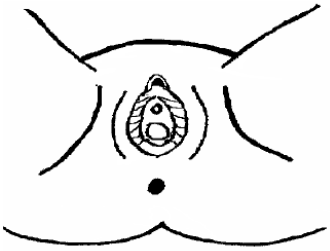


Vulvar / Perineal Pain
(pain outside and around the vagina and anus)

If you have vulvar pain, shade the painful areas and write a number from 1 to 10 at the painful sites. (10 = most severe pain imaginable)

Is your pain relieved by sitting on a commode seat? ☐ Yes ☐ No

Right Left



Infertility Questions *(skip this section if you are NOT currently trying to conceive)*

How many months have you and your husband tried to conceive?	

Are you working with any health care provider(s)? ☐ **No** *(We strongly recommend that you work with one)* ☐ **Yes** *(Please provide details)*

Name	Specialty	Phone/Fax	Records mailed ☐ Y ☐ N
Name	Specialty	Phone/Fax	Records mailed ☐ Y ☐ N

Previous Fertility-Related Investigations: *(Please check if you have had any of the following and provide results from the most recent testing)*

Test	**Month/Year**	**Results and Comments**
☐ Ultrasound of uterus and ovaries		
☐ Ultrasound of the ovaries to look at ovulation (follicle tracking)		
☐ Hysterosalpingogram (X-ray assessment of the uterus and fallopian tubes)		
☐ Hysteroscopy (camera visualization of the uterine cavity)		
☐ Endometrial biopsy		
☐ D&C (scraping of the lining of the womb)		
☐ Post-coital test (looking at sperm taken from your cervix after intercourse)		
☐ Day 3 or early cycle blood test		
☐ Day 21 or late cycle blood test (progesterone/ovulation)		
☐ Other blood tests or investigations		

Previous Fertility-Related Diagnosis *(Please check if you have, or have had, any of the following)*

☐ Unexplained Infertility	☐ Recurrent Miscarriage	☐ Endometriosis	☐ Polycystic Ovaries (PCOS / PCOD)
☐ Low Progesterone	☐ Low Estrogen	☐ Not Ovulating	☐ Leutenized Unruptured Follicle (LUF)
☐ Fibroids in or on Uterus	☐ Pelvic Adhesions / Scar Tissue	☐ Abnormal Ovulation	☐ Hostile / Limited Cervical Mucus
☐ Polyps in Uterus	☐ Blocked / Damage Tubes	☐ Male Factor Infertility	☐ Adhesions in Uterus (Asherman)
☐ Others:			

Previous Fertility-Related Surgery *(Please check if you have had any of the following and provide the year(s) of the surgery)*

☐ Superficial treatment for endometriosis. Year:	☐ Excisional treatment for endometriosis. Year:
☐ Surgery for Uterine Polyps. Year:	☐ Fallopian tube reconstruction. Year:
☐ Ovarian surgery for Polycystic Ovaries. Year:	☐ Surgery for Fibroids (Myomectomy). Year:
☐ Others:	

Gynecological and Obstetrical History			
Age of first menses:	Age pelvic pain began:	Are you postmenopausal:	Are you trying to conceive:
What is your period like? ☐ Light ☐ Moderate ☐ Heavy		Period every days	☐ Regular ☐ Irregular
No. of pregnancies:	No. of live births:	No. vaginal deliveries:	No. of cesarean section:
No. of living children:	No. of miscarriages:	No. elective abortions :	No. ectopic:
Complications around delivery? ☐ Vacuum/Forceps ☐ Medication for bleeding ☐ Vaginal laceration ☐ Postpartum Hemorrhage			
Are you using any form of hormonal birth control currently? ☐ No ☐ Yes (what type)			
Did you have trouble getting pregnant? ☐ N/A ☐ No ☐ Yes – How long did you try before getting pregnant? months			
How did you achieve pregnancy? ☐ Spontaneous ☐ Ovulation Induction ☐ IUI ☐ IVF ☐ Other:			
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?			☐ Yes ☐ No
Date of your last PAP and results:			
Have you ever had these procedure (If so, please provide year)?	☐ Colposcopy	☐ LEEP	☐ Cone
Have you ever been diagnosed with sexually transmitted infection or pelvic inflammatory disease?			☐ Yes ☐ No

Current Health Care Providers *(physicians and non-physicians)*			
Name	**Specialty**	**Phone and fax number**	**Records attached?**
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
Current Pain Management Doctor:			☐ Y ☐ N

Medical History *(Please check if you have, or have had, any of the following)*			
☐ Anemia	☐ Arthritis	☐ Asthma	☐ Bladder disease
☐ Cancer	☐ Anxiety	☐ Chlamydia	☐ Chron's / Ulcerative Colitis
☐ Congenital Heart Disease	☐ Depression	☐ Deep Vein Thrombosis (DVT)	☐ Emphysema / COPD
☐ Epilepsy / Seizures	☐ Fibromyalgia	☐ Diabetes	☐ Glaucoma
☐ Gonorrhea	☐ Heart Attack (MI)	☐ Heart Murmur / Valve disease	☐ Heart Failure
☐ Hepatitis	☐ Heartburn / Reflux (GERD)	☐ Herpes	☐ HIV / AIDS
☐ HPV	☐ Hypertension	☐ Irritable Bowel Syndrome	☐ Interstitial Cystitis
☐ Kidney Disease / Renal Failure	☐ Kidney / Ureteral Stones	☐ Migraine Headaches	☐ Osteoporosis / Osteopenia
☐ Pulmonary Embolus (PE)	☐ Sickle Cell Disease / Trait	☐ Hemophilia	☐ Stroke
☐ Syphilis	☐ Thyroid Disease	☐ Trichomonas	☐ Tuberculosis
☐ Pneumothorax	☐ Hemoptysis (Cough up Blood)	☐ Pancreatitis	☐ Gallbladder disease / stones
☐ Others:			
Have you ever had a blood transfusion? ☐ No ☐ Yes		**Do you have any objection to blood transfusion? ☐ No ☐ Yes**	

Surgeries *(please list all your surgeries in chronological order starting with your first procedure)*			
Month / Year	**Procedure and findings**	**How much help did the surgery provide?**	**Surgical Report attached?**
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

Surgical History *(Please check if you have had any of the following)*			
☐ Single Ovary Removed	☐ Both Ovaries Removed	☐ Ovarian Cyst Removed	☐ Gallbladder Removed
☐ Cesarean Section	☐ Dilation and Curettage (D&C)	☐ Heart Surgery	☐ Hernia Repair
☐ Hysteroscopy	☐ Breast Surgery	☐ Appendectomy	☐ Cervical Cerclage
☐ Tubal Ligation	☐ Fallopian Tube(s) Surgery	☐ Fallopian Tube(s) Removed	☐ Tonsillectomy / Adenoidectomy
☐ Laparotomy (Open Surgery)	☐ Laparoscopy (Includes Robotic)	☐ Uterus removed (Hysterectomy)	☐ Vulvar Surgery / Biopsy
☐ Others:			
Any prior complications to anesthesia? ☐ No ☐ Yes (please specify)			

Review of Systems *(Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain)*		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Appetite:
☐ Lungs	☐ Circulation	
☐ Others:		

Medical History			
List your prescribed drugs			
Name the drug	Strength	Frequency	Reason
List your over-the-counter drugs, such as vitamins and supplements			
Name the drug	Strength	Frequency	Reason
Allergies to medications			
Name the Drug		Reaction You Had	

Health Habits			
☐ **Alcohol**	What type of alcohol do you drink?	How many drinks per week?	
☐ **Tobacco**	If yes, how many packs of cigarettes per day?	For how many years?	Or years quit?
☐ **Drugs**	Do you currently use recreational / street drugs? ☐ Y ☐ N	Have you ever given yourself street drugs with a needle? ☐ Y ☐ N	
Comments:			

PLEASE PROVIDE YOUR NARRATIVE SUMMARY ON A SEPARATE SHEET OF PAPER