PAIN CARE BOISE

PELVIC QUESTIONNAIRE

Patient Name:	Today's Date:
DOB:	Age:

Office Use:

Where is your pain located?
Date of injury ~or~ When did your pain start / /
How did your pain problem start?

Please mark "YES" or "NO" for each of the following conditions:	
☐ Y ☐ N	Have you had any prior surgery for this or similar type pain problem? If yes, when? / /
☐ Y ☐ N	Is there BLOOD in your URINE?
☐ Y ☐ N	Is there BLOOD in your STOOL?
☐ Y ☐ N	Do you have a history of HEMORRHOIDS?
☐ Y ☐ N	Have you lost control of your BLADDER?
☐ Y ☐ N	Have you lost control of your BOWEL?
☐ Y ☐ N	Do you have DIARRHEA?
☐ Y ☐ N	Do you have CONSTIPATION? If yes, when was your last bowel movement? / /
☐ Y ☐ N	Do you have pain with BOWEL MOVEMENTS?
☐ Y ☐ N	Do you have a history of IRRITABLE BOWEL SYNDROME (IBS)?
☐ Y ☐ N	Do you have a history of CROHNS?
☐ Y ☐ N	Do you have a history of ULCERATIVE COLITIS?
☐ Y ☐ N	Do you have a history of DIVERTICULITIS?
☐ Y ☐ N	Do you have a history of ENDOMETRIOSIS?
☐ Y ☐ N	Do you have frequent URINARY TRACT INFECTIONS (UTI)?
☐ Y ☐ N	Do you have PAIN with URINATION?
☐ Y ☐ N	Do you have PAIN with SEXUAL INTERCOURSE?
☐ Y ☐ N	Do you have a history of PHYSICAL ABUSE?
☐ Y ☐ N	Do you have a history of SEXUAL ABUSE?

FEMALES ONLY:

☐ Y ☐ N	Are you still having periods?
☐ Y ☐ N	Are your periods regular?
☐ Y ☐ N	Have you had an OB/GYN evaluation? If yes, by whom? When: / /
☐ Y ☐ N	Has treatment included ORAL CONTRACEPTIVES?
☐ Y ☐ N	Has treatment included LUPRON?

Office Use: