

## PAIN QUESTIONNAIRE

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Age: \_\_\_\_\_ G: \_\_\_\_\_ P: \_\_\_\_\_ LMP: \_\_\_\_\_ Cycle day: \_\_\_\_\_

1. Pain Location (List each different location and number it)      2. Date First Noticed      3. Events Preceding Pain      4. Pain Description (Adjectives that patients use to describe typical pain and list cycle days)      5. Pain Intensity (Rate each pain)

PAIN LOCATION	ONSET	EVENTS PRECEDING	DESCRIPTION	RATE PAIN FROM 0-10

6. Overall interference of pain with life (zero to 10)
- |       |        |                   |           |                     |               |        |
|-------|--------|-------------------|-----------|---------------------|---------------|--------|
| Work  | School | Social Activities | Childcare | Sports and Exercise | Relationships | Other: |
| _____ | _____  | _____             | _____     | _____               | _____         | _____  |

7. Description of things that:

<u>INCREASE PAIN</u>			<u>DECREASE PAIN</u>		
Intercourse	Yes	No	Lying down	Yes	No
Bowel movement	Yes	No	Heating pad	Yes	No
Urination	Yes	No	Hot bath	Yes	No
Physical activities	Yes	No	Medication	Yes	No
Other:	Yes	No	Other:	Yes	No

8. Prior treatment or medical workup:

Surgeries:	Date:	Diagnosis:
GI Studies:	Date:	Diagnosis:
Other:		

9. Use of medication:

<u>DATES:</u>	<u>EFFECTIVENESS:</u>
A.	
B.	
C.	
D.	

10. Current symptoms other than pain:

- A. Bleeding
- B. Bowel problems/nausea
- C. Headache
- D. Fatigue
- E. Other