

# Pelvic Pain Questionnaire for Girls and Women



Pelvic Pain  
Foundation  
OF AUSTRALIA

Thank you for completing this questionnaire. It includes questions about you, your pain, your medical history and your family history.

For some of the questions you will be asked how bad your pain is on a scale from 0-10. A score of 0 would mean no pain at all, and 10 would be the worst pain you can imagine.

Other questions ask you to circle the answer that describes your pain best.

If your problems vary from month to month, think about how they might affect you on a typical month over the last 3 months.

You will find information on pelvic pain for you and your family at [www.pelvicpain.org.au](http://www.pelvicpain.org.au)

Firstly, please describe the problem that worries you most

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## You and your pain

1. Your age \_\_\_\_\_

2. How many days over an average month would you have pelvic pain or discomfort of *any* kind, even mild pain? (number 1-30) \_\_\_\_\_

3. How many days over an average month would you be *entirely* well with no pelvic discomfort at all? (number 1-30) \_\_\_\_\_

*(Please note that the answer to Q 2 and Q 3 should add up to 30)*

## Your Operations

4. Please list any operations you have had and the year they were done.

_____	Year _____
_____	Year _____
_____	Year _____
_____	Year _____
_____	Year _____
_____	Year _____
_____	Year _____

If you have any operation records, please bring these with you to your appointment.

## Your Medications

5. Are you currently using any medications, including over-the-counter or complementary medicines?

Medications I use with periods

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Medications I use every day

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Medications I use occasionally

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6. Do you have any allergies? \_\_\_\_\_

## Your Periods

7. How old were you when your periods started? \_\_\_\_\_

8. When was the first day of your last period? \_\_\_\_\_

9. How long between the first day of one period and first day of your next period? \_\_\_\_\_

10. How heavy is the bleeding?                      Light / Medium / Heavy / Variable

11. Are you currently using any of these hormonal medications?

Implanon                                      Yes / No

Mirena IUCD                                  Yes / No

Oral contraceptive pill                      Yes / No    (name of pill) \_\_\_\_\_

Other    Yes / No    (name) \_\_\_\_\_

No, I don't use any hormonal preparations

## Period Pain

12. Do you have period pain? Yes / No / Occasionally    Pain Score (0-10) \_\_\_\_\_

*If so*, how old were you when your periods became painful? \_\_\_\_\_

How many days each month do you have period pain for? \_\_\_\_\_

If you now have pain of some kind on most days, when did it change from pain just with periods, to pain on most days? \_\_\_\_\_

Where do you feel your period pain?

Low abdomen at the front / Lower back / Left side lower abdomen / Right side lower abdomen / Front of the legs / Back of the legs / Foot / Anal area / Other

Does the contraceptive pill help your period pain?

Yes, a lot / a little / not at all / I have never tried the pill

Do period pain medications (ibuprofen, Ponstan, Naprogesic etc) help your period pain?

Yes, a lot / a little / not at all / I have never tried these medications

## Stabbing or sudden pains

13. Do you have sudden or stabbing pains in the pelvis or abdomen?

Yes / No / Occasionally      Pain score (0-10) \_\_\_\_\_

*If so*, When did these pains start? \_\_\_\_\_

Where do you feel these pains?

Low abdomen at the front / Lower back

Left side lower abdomen / Right side lower abdomen

Front of the legs / Back of the legs / Foot / Anal area

Other \_\_\_\_\_

Do any exercises, movements or positions make these pains worse? Which ones?

\_\_\_\_\_

14. What exercise do you do?

\_\_\_\_\_

## Your Bladder

15. Are you happy with your bladder function? Yes / No / Mostly

16. How many times do you pass urine each day?

During the day, while awake? \_\_\_\_\_

At night, after going to sleep? \_\_\_\_\_

17. *If you have bladder problems,*

When did these bladder problems start? \_\_\_\_\_

When you need to pass urine, can you wait until later, or do you need to go straight away? \_\_\_\_\_

Do you have bladder pain?      Yes / No / Only when I try to 'hold on'

Do you have pain passing urine?      Yes / No / Only when pain is severe

Are there times when you find it difficult to start passing urine?      Yes / No

How much fluid do you drink each day? \_\_\_\_\_

Have you ever had a bladder infection?      Yes / No

## Your Bowel

18. Do you have problems with your bowel? Yes / No / Occasionally

*If so*, How old were you when your bowel problems started? \_\_\_\_\_

Do you have constipation?      Yes / No / Sometimes / Only with periods

Do you have diarrhoea?      Yes / No / Sometimes / Only with periods

Do you feel bloated?      Yes / No / Sometimes / Only with periods

Do you have bowel pain?      Yes / No / Occasionally / Only with periods

## Your Diet

19. Are there foods that don't suit you? Yes / No

Wheat Yes / No

Dairy foods Yes / No

Fatty foods Yes / No

Other foods \_\_\_\_\_

20. How would you describe your diet? \_\_\_\_\_

## Headaches

21. Do you get headaches? Yes / No / Occasionally

*If so,* At what age did your headaches start? \_\_\_\_\_

Do you get headaches or migraines at period time? Yes / No / Occasionally

Pain score \_\_\_\_\_

Do you get bad headaches or migraines at other times? Yes / No / Occasionally

Pain Score \_\_\_\_\_

Do you get milder background headaches at other times? Yes / No / Occasionally

Pain Score \_\_\_\_\_

22. Have you ever been diagnosed with migraines? Yes / No

23. How many days a month do you have a headache, even a mild headache? \_\_\_\_\_

## Your Vulva (The Vulva is the skin between your legs near the opening of the vagina)

24. Do you have vulval pain or soreness? Yes / No Pain score (0-10) \_\_\_\_\_

*If so,* when would you get this pain? (circle as many as apply)

Anytime / with intercourse / using tampons / sitting / only with a vaginal infection

## Your General Wellbeing

25. Do you have any of the following symptoms?

Unusual tiredness or fatigue? Yes / no / only with periods

Poor sleep? Yes / no / only with periods

Unusual sweating? Yes / no / only with periods

Dizziness or feeling faint? Yes / no / only with periods

Anxiety? Yes / no / only with periods

Low mood? Yes / no / only with periods

Nausea Yes / no / only with periods

## Your Sexual Wellbeing

26. Are you currently or have you ever been in a sexual relationship? Yes / No

*If so*, Do you feel pain or discomfort during sexual activity? Yes / No / Occasionally  
Pain score \_\_\_\_\_

Has intercourse always been painful? Yes / No

If not, at what age did intercourse become painful? \_\_\_\_\_

Have there been distressing sexual events during your life that you would like to discuss further with us? Yes / No

## Pregnancy and Contraception

27. Have you ever been pregnant? Yes / No

28. Do you have children? \_\_\_\_\_ How many? \_\_\_\_\_

29. Are you currently trying to become pregnant? \_\_\_\_\_

*If not*, what type of contraception are you using? \_\_\_\_\_

30. When was your last smear test? \_\_\_\_\_ Was it normal? \_\_\_\_\_

## Your General Health

31. Do you smoke cigarettes? \_\_\_\_\_ How many? \_\_\_\_\_

32. Do you have any of the following medical conditions?

Arthritis or an Auto-immune Disorder?	Yes / No
Thyroid Disease	Yes / No
Hepatitis	Yes / No
Coeliac Disease	Yes / No
Ulcerative Colitis or Crohns Disease	Yes / No
Clots in the legs or lungs, or a blood clotting disorder	Yes / No
Other medical conditions? (Please list) _____	

## Your Family History

33. Does anyone in your family have any of the following medical conditions?

Long term pain condition	Yes / No
Endometriosis	Yes / No
Thyroid disease	Yes / No
Coeliac Disease, Ulcerative Colitis, Crohns Disease	Yes / No
Rheumatoid Arthritis or SLE	Yes / No
Cancer of any kind	Yes / No
Clots in the legs or lungs, or a blood clotting disorder	Yes / No

**Thank you for completing this questionnaire.**