

Patient Name: _____

Date Form Completed: _____ DOB: _____

Patient Questionnaire

PATIENT INFORMATION:

Height: _____ Weight: _____ Age: _____

Problems you would like Dr. Cook to address:

1. _____
2. _____
3. _____
4. _____

GYNECOLOGICAL HISTORY:

Menarche (age when periods began)	Age when pelvic pain began	How long have you suffered with this pain?	History of breast disease/lumps or masses?
			<input type="checkbox"/> Yes Last Eval: ____/____/____

If you are still having menstrual periods, please complete the following questions:

Periods are: Light Moderate Heavy Bleed through protection
 How many days between your periods? _____ How many days of menstrual flow? _____
 What day does the pain start? _____ Are periods regular? Yes or No
 Do you pass clots in menstrual flow? Yes or No

Are you using any type of birth control at this time?: Yes No, If Yes, what type: _____

Are you trying to get pregnant? Yes No How long have you been trying? _____

Number of times pregnant	Number of deliveries	Number of Vaginal or C-Section deliveries	Weight of Babies	Episiotomy or Tears	Number of Living Children	Number of Miscarriages (M) Still Born (SB) or Pregnancy Terminations (PT)	If unable to conceive – circle infertility treatments you have tried?
0 1 2 3	0 1 2 3	V:		E:	0 1 2 3	M:	IUI IVF
4 5 6 7	4 5 6 7	C:		T:	4 5 6 7	SB: PT:	Clomid Other:

Have you had any of the following organs removed, if so when:

<input type="checkbox"/> Uterus ____/____/____	<input type="checkbox"/> Right Ovary ____/____/____	<input type="checkbox"/> Left Ovary ____/____/____	<input type="checkbox"/> Appendix ____/____/____	<input type="checkbox"/> Gallbladder ____/____/____
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How many days of each month are you unable to function normally? _____

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NUMERIC PAIN INTENSITY SCALE

The numeric pain intensity scale is an objective way of measuring the amount of pain that you are experiencing. A level of zero is no pain and a level of 10 is the worst pain you can imagine. Place an X over the level of pain that you are experiencing.

OVERALL PAIN

1. Average overall Pain:	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
2. Lowest pain level in last month:	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
3. Greatest pain level in last month:	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
4. Maximum pain level at which you can function:	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

CYCLIC PAIN Not Applicable

1. Pain prior to period	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
2. Cramps prior to period	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
3. Pain during period	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
4. Cramps during period	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
5. Pain after period	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
6. Mid-cycle pain (Ovulation)	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

PAIN WITH SEX I am not sexually active

1. Deep pain with intercourse	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
2. Pain with penetration	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
3. Vaginal burning pain with intercourse	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
4. Pain lasting hours or days after sex	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
5. Pain with orgasm	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

PAIN WITH BOWEL MOVEMENT

1. Pain prior to bowel movement (left side)	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
2. Pain prior to bowel movement (general)	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
3. Pain with bowel movement	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

OTHER

1. Pain down left leg	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
2. Pain down right leg	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
3. Vulva burning or itching	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
4. Heavy periods	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
5. Irregular periods	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

SYSTEMIC SYMPTOMS

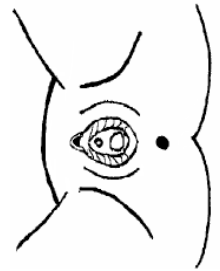
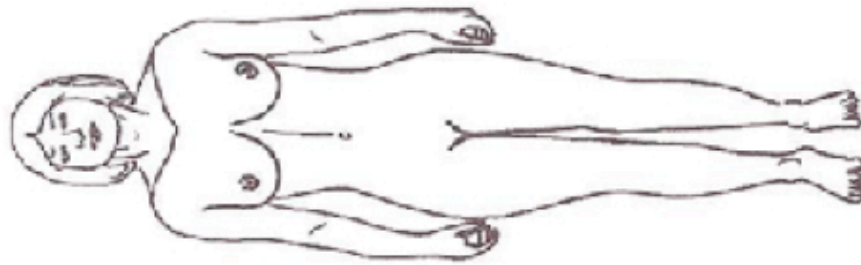
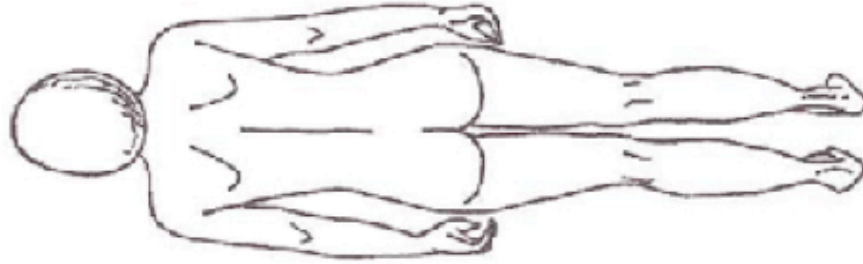
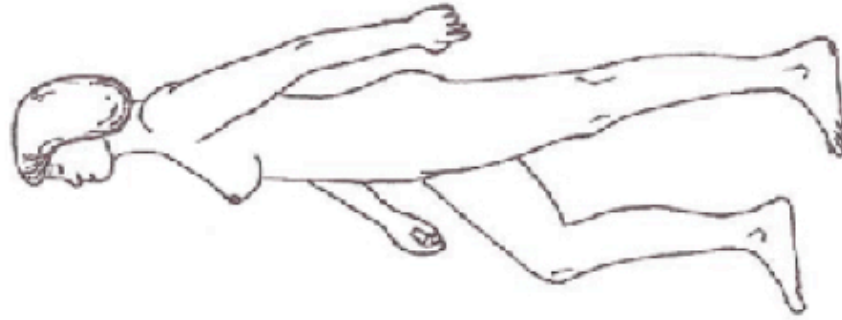
1. Backache	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
2. Bloating	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
3. Chronic Yeast	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
4. Depression	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
5. Fatigue	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
6. Flu-like symptoms	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
7. Migraine headaches	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
8. Muscle/Joint Pain	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
9. Stress	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
10. PMS Symptoms (list below)	0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

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Pain Map

Mark your areas of 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=the most severe pain imaginable)

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PAST HEALTH CARE PROVIDERS

What physicians or non-physicians health care providers have you previously seen for treatment?

Name of Provider	Address	Phone/Fax	Are you sending Medical Records from this provider?
Current Pain Management Doctor:			

PREVIOUS SURGICAL PROCEDURES

Please list all of your surgeries in chronological order, starting with your first procedure

Date	Hospital	Procedure	Percentage improved after the surgery?	How long did improvement last?	Is your Operation Report attached?

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PAST MEDICAL HISTORY

Hospitalizations (excluding surgery and childbirth) _____

Injuries (falls, back injury, accidents, etc.) _____

Medical Illnesses (past and present) _____

PAIN MANAGEMENT:

What do you think is causing your pain? _____

Do you remember an event associated with the onset of your pain? _____

What pain medications have you tried: (Check those that have been effective)?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many days a month, on average, are you pain free? _____

What helps improve your pain? _____

What makes your pain worse? _____

URINARY TRACT SYMPTOMS

Check all that apply or Check here if none apply

<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Frequent Bladder Infections
<input type="checkbox"/> Get up to urinate more than twice a night	<input type="checkbox"/> Urinate during the day more than 15 times
<input type="checkbox"/> Small volumes of urine	<input type="checkbox"/> Need to urinate with little warning
<input type="checkbox"/> Sensation of fullness or incomplete emptying after urination	<input type="checkbox"/> Loss of urine when coughing, laughing or sneezing

CURRENT BOWEL/GASTROINTESTINAL SYMPTOMS

Check all that apply or Check here if none apply

<input type="checkbox"/> Pain with bowel movements	<input type="checkbox"/> Intestinal Cramping
<input type="checkbox"/> Abdominal fullness, bloating or swelling	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation	<input type="checkbox"/> More than 3 bowel movements a day
<input type="checkbox"/> Require laxative to have a bowel movement	<input type="checkbox"/> Loose or watery stools
<input type="checkbox"/> Fewer than 3 bowel movements a week	<input type="checkbox"/> Blood with bowel movement
<input type="checkbox"/> Hard or lumpy stools	<input type="checkbox"/> Relief of pain with bowel movements
<input type="checkbox"/> Passing mucus (slippery white material) during BM	<input type="checkbox"/> Urgency—having to rush to the bathroom for BM
<input type="checkbox"/> Feeling of incomplete emptying after a BM	<input type="checkbox"/> Other: _____

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PAST MEDICAL TREATMENTS OF PRESENT PROBLEM

Check all that apply, also circle those that have been helpful

MEDICAL

<input type="checkbox"/> Lyme	<input type="checkbox"/> Colic Child	<input type="checkbox"/> Tonsils Removed	<input type="checkbox"/> Bottle fed	<input type="checkbox"/> Ear aches
<input type="checkbox"/> Antifungal Meds	<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Birth Control Pills	<input type="checkbox"/> Danazol	<input type="checkbox"/> Depro-Provera
<input type="checkbox"/> Lupron Date of last injection: ___/___/___ did it help symptoms? Y / N	<input type="checkbox"/> Nerve Medications (Neurontin)	<input type="checkbox"/> Narcotic Pain Medications	<input type="checkbox"/> Non-narcotic Pain Medications	<input type="checkbox"/>

PROCEDURES

<input type="checkbox"/> Nerve Blocks	<input type="checkbox"/> Cryo-ablation of nerve	<input type="checkbox"/> Implantable Devices	<input type="checkbox"/> Radiotherapy	<input type="checkbox"/> Other
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SURGERY

<input type="checkbox"/> Removal of Endometriosis Date of Diagnosis: ___/___/___	<input type="checkbox"/> Bowel Resection Date: ___/___/___	<input type="checkbox"/> Hernia Repair Date: ___/___/___	<input type="checkbox"/> Removal of Scar Tissue Date: ___/___/___	<input type="checkbox"/> Other: ___/___/___
Classification of Endometriosis:				
<input type="checkbox"/> Stage I (Minimal)	<input type="checkbox"/> Stage II (Mild)	<input type="checkbox"/> Stage III (Moderate)	<input type="checkbox"/> Stage IV (Severe)	<input type="checkbox"/> Not Known

THERAPEUTIC

<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Massage	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Psychotherapy	<input type="checkbox"/> Chiropractic
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LIFE STYLE CHANGES

<input type="checkbox"/> Diet/Nutrition	<input type="checkbox"/> Exercise	<input type="checkbox"/> Meditation	<input type="checkbox"/> Yoga	<input type="checkbox"/> Other
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ALTERNATIVE

<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Traditional Chinese Supplements	<input type="checkbox"/> Herbal Supplements	<input type="checkbox"/> Homeopathic	<input type="checkbox"/> Naturopathic
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DIAGNOSTIC TESTS AND PROCEDURES AND DATES PERFORMED: CIRCLE ANY ABNORMAL LABS

<input type="checkbox"/> PAP Smear ___/___/___	<input type="checkbox"/> Abnormal PAP ___/___/___	<input type="checkbox"/> LEEP ___/___/___	<input type="checkbox"/> Cervix Procedure ___/___/___	<input type="checkbox"/> Last Annual Exam ___/___/___
<input type="checkbox"/> Mammogram ___/___/___	<input type="checkbox"/> Abd. Ultra Sound ___/___/___	<input type="checkbox"/> CT ___/___/___	<input type="checkbox"/> MRI ___/___/___	<input type="checkbox"/> Bone Density Scan ___/___/___
<input type="checkbox"/> Hysterosalpingo ___/___/___	<input type="checkbox"/> Hysteroscopy with D&C ___/___/___	<input type="checkbox"/> Upper G.I. ___/___/___	<input type="checkbox"/> HPV Screen ___/___/___	<input type="checkbox"/> HIDA Scan ___/___/___
<input type="checkbox"/> Stool Analysis ___/___/___	<input type="checkbox"/> Colonoscopy ___/___/___	<input type="checkbox"/> Barium Enema ___/___/___	<input type="checkbox"/> Insulin Resistance ___/___/___	<input type="checkbox"/> Thyroid ___/___/___

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CURRENT MEDICATIONS

Please list all current medications

Name	Dose	Amount	Frequency	Prescribing doctor & their telephone No.

Check any of the following you have used in the past or are currently using:

- marijuana cocaine amphetamines
 barbiturates heroin other

Check all that apply:

Family history of substance abuse: 1) Alcohol , 2) Illegal Drugs , 3) Prescription Drugs

Personal history of substance abuse: 1) Alcohol , 2) Illegal Drugs , 3) Prescription Drugs

How many cigarettes do you smoke a day? _____ For how many years? _____

When do you smoke your 1st cigarette of the day?: _____

How many alcoholic beverages do you consume weekly? _____

Have you ever received treatment for substance abuse? Yes No

Are you interested in alternative medical treatments?

- _____ Yes, I would like to avoid prescription medications if possible
 _____ Yes, I would like the best that traditional and alternative medicine have to offer
 _____ Maybe, I would consider alternative medicine in addition to traditional medications
 _____ No, I am not interested in alternative medical treatments

ALLERGIES AND SENSITIVITIES

Please list prescription medications, environmental, latex allergies or sensitivities. Foods will be listed on another page.

Allergen	Reaction
Latex: Yes or No	

Patient Name: _____

Date Form Completed: _____ DOB: _____

REVIEW OF SYSTEMS: *Check negative or all that apply*

Allergic/ Immunological	<input type="checkbox"/> Negative	<input type="checkbox"/> Pollen Allergy <input type="checkbox"/> Food Allergy	<input type="checkbox"/> Dust Allergy <input type="checkbox"/> Mold Allergy	<input type="checkbox"/> Autoimmune Disease
Constitutional	<input type="checkbox"/> Negative	<input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Low Grade Fever
Eyes	<input type="checkbox"/> Negative	<input type="checkbox"/> Vision Change	<input type="checkbox"/> Glasses	<input type="checkbox"/> Contacts
ENT/ Mouth	<input type="checkbox"/> Negative	<input type="checkbox"/> Ulcers <input type="checkbox"/> Headaches	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Tinnitus
Cardiovascular	<input type="checkbox"/> Negative	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Pre-Hypertension	<input type="checkbox"/> Swelling Ankles <input type="checkbox"/> Hypertension	<input type="checkbox"/> Palpitation
Respiratory	<input type="checkbox"/> Negative	<input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma	<input type="checkbox"/> Coughing Blood <input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of Breath
Gastrointestinal	<input type="checkbox"/> Negative	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Pain <input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Nausea & Vomiting <input type="checkbox"/> Craving sweets
Genitourinary	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequency <input type="checkbox"/> Interstitial Cystitis	<input type="checkbox"/> Low Sex Drive <input type="checkbox"/> Urgency <input type="checkbox"/> Incontinent	<input type="checkbox"/> Pain with Urination <input type="checkbox"/> Incomplete Emptying
Musculoskeletal	<input type="checkbox"/> Negative	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Joint Pain
Skin/ Breast	<input type="checkbox"/> Negative	<input type="checkbox"/> Painful Breast(s)	<input type="checkbox"/> Discharge	<input type="checkbox"/> Masses
Neurological	<input type="checkbox"/> Negative	<input type="checkbox"/> Passing Out	<input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness
Psychiatric	<input type="checkbox"/> Negative <input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Crying <input type="checkbox"/> Bipolar	<input type="checkbox"/> Depression <input type="checkbox"/> Obsessive- Compulsive Disorder	<input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Schizophrenia
Endocrine	<input type="checkbox"/> Negative	<input type="checkbox"/> Diabetes <input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Insulin Resistance <input type="checkbox"/> Difficulty Concentrating
Hematology/ Lymphatic	<input type="checkbox"/> Negative	<input type="checkbox"/> Easy Bruising <input type="checkbox"/> Blood Clots	<input type="checkbox"/> Bleeding Tendency <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Anemia

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FAMILY HISTORY

(Mother=M, Father=F, Brother=B, Sister=S, Grandparent=G, Child=C, Aunt=A, Uncle=U)

- | | | |
|------------------------------|--------------------------------|---|
| 1. _____ Allergies | 8. _____ Endometriosis | 15. _____ IBS |
| 2. _____ Alcoholism | 9. _____ Epilepsy | 16. _____ Kidney |
| 3. _____ Asthma | 10. _____ Fibromyalgia | 17. _____ Lupus |
| 4. _____ Auto Immune Disease | 11. _____ Gall Bladder Trouble | 18. _____ Stroke |
| 5. _____ Bleeding Disorder | 12. _____ Heart Disease | 19. _____ Thyroid |
| 6. _____ Depression | 13. _____ High Blood Pressure | 20. _____ Cancer |
| 7. _____ Diabetes | 14. _____ Hypoglycemia | Type/s: <input type="checkbox"/> Breast <input type="checkbox"/> Ovarian <input type="checkbox"/> Colon |
| | | Other: _____ |

SOCIAL HISTORY

Whom do you live with?	Were you ever the victim of sexual abuse as a child (<14 years old)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Education:	Have you ever been a victim of physical abuse by a family member? <input type="checkbox"/> Yes <input type="checkbox"/> No
What work are you trained for:	Have you been a victim of emotional abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No
What type of work are you doing:	Have you received therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:

DIET, EXERCISE and LIFE STYLE

Describe your diet on an average day, Please be specific (and honest) as possible:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

Patient Name: _____

Date Form Completed: _____ DOB: _____

Do you react to foods? Yes No

Reactions: _____

Describe your weekly exercise routine:

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

List any chemicals, metals, dusts, molds or fumes to which you are repeatedly exposed:

Are you happy and/or satisfied with your sex life? Yes No

How would you describe your libido (sexual desire)? Low Average High

Are you willing to change your lifestyle/habits to improve your health? Yes No

Does your spiritual life play an important role in your life? Yes No

WHAT ARE YOUR EXPECTATIONS OF TREATMENT?

Patient Name: _____

Date Form Completed: _____ DOB: _____

Please check any items that may apply:

- Exposure to tick infested areas Frequent outdoor activities Other household members with Lyme?
 Hiking Fishing Hunting Camping Gardening Ticks noted on pets
 Do you remember being bitten by a tick? NO YES If yes, When: _____
 Do you remember having the "bull's eye rash"? NO YES If yes, When: _____
 Any other rash? NO YES If yes, Describe: _____

Please rate the following symptoms:

Never	Slightly	Moderate	Severely	
0	1	2	3	Unexplained fevers, sweats, chills or flushing
0	1	2	3	Unexplained weight changes (circle one: Loss or Gain)
0	1	2	3	Fatigue, tiredness, poor stamina
0	1	2	3	Unexplained hair loss
0	1	2	3	Swollen glands: list areas
0	1	2	3	Sore throat
0	1	2	3	Pelvic Pain
0	1	2	3	Unexplained menstrual irregularity
0	1	2	3	Unexplained milk production; breast pain
0	1	2	3	Irritable bladder or bladder dysfunction
0	1	2	3	Loss of Libido
0	1	2	3	Upset stomach or abdominal pain
0	1	2	3	Change in bowel function - (circle one: Constipation or Diarrhea)
0	1	2	3	Chest pain or rib soreness
0	1	2	3	Shortness of breath, cough
0	1	2	3	Heart palpitations, pulse skips, heart block
0	1	2	3	Any history of a heart murmur or valve prolapse?
0	1	2	3	Joint pain or swelling: List joints:
0	1	2	3	Stiffness of the joints or back
0	1	2	3	Muscle pain or cramps
0	1	2	3	Twitching of the face or other muscles
0	1	2	3	Headache
0	1	2	3	Neck creaks and cracks, neck stiffness, neck pain
0	1	2	3	Tingling, numbness, burning, or stabbing sensations, shooting pains, skin hypersensitivity
0	1	2	3	Facial paralysis (Bell's Palsy)
0	1	2	3	Eyes/Vision: double, blurry, increased floaters, light sensitivity
0	1	2	3	Ears/Hearing: buzzing, ringing, ear pain, sound sensitivity
0	1	2	3	Increased motion sickness, vertigo, poor balance
0	1	2	3	Lightheadedness, wooziness, unavoidable need to sit or lie down
0	1	2	3	Tremor
0	1	2	3	Confusion, difficulty in thinking
0	1	2	3	Difficulty with concentration, reading
0	1	2	3	Forgetfulness, poor short term memory, poor attention, problem absorbing new information
0	1	2	3	Disorientation: getting lost, going to wrong places
0	1	2	3	Difficulty with speech or writing; word or name block
0	1	2	3	Mood swings, irritability, depression
0	1	2	3	Disturbed sleep – too much, too little, fractionated, early awakening
0	1	2	3	Exaggerated symptoms or worse hangover from alcohol

Total:	Grand Total:	Average:
0		

Patient Name: _____

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Pelvic Pain and Urinary Frequency Questionnaire (PUF)

Circle the answer that best describes how you feel for each question

		0	1	2	3	4	Symptom Score	Bother Score
1	a. How many times do you urinate during waking hours?	3 to 6	7 to 10	11 to 14	15 to 19	20+		
2	a. How many times do you urinate at night?	0	1	2	3	4+		
	b. If you get up at night to urinate, to what extent does it usually bother you?	None	Mild	Moderate	Severe			
3	a. If you are sexually active, do you now have or have you ever had pain or urgency to urinate during or after sexual intercourse?	Never	Occasionally	Usually	Always			
	b. If you are sexually active, has pain or urgency ever made you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
4	a. Do you have pain associated with your bladder or in your pelvis, vagina, lower abdomen, urethra or perineum?	Never	Occasionally	Usually	Always			
5	a. Do you still have urgency shortly after urinating?	Never	Occasionally	Usually	Always			
6	a. When you have pain is it usually _____?	None	Mild	Moderate	Severe			
	b. How often does your pain bother you?	Never	Occasionally	Usually	Always			
7	a. When you have urgency, is it usually _____?	None	Mild	Moderate	Severe			
	b. How often does the urgency bother you?	Never	Occasionally	Usually	Always			

SYMPTOM SCORE

BOTHER SCORE

TOTAL SCORE

Patient Name: _____

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How has this chronic pelvic pain affected your life?

To return these forms you can either 1) scan and email your forms back to michelle@vitalhealth.com, 2) fax your forms to (408) 358-1009, or 3) mail them to 14830 Los Gatos Blvd., Suite 300 Los Gatos, CA 95032