Patient Name: ______________________________

Date Form Completed: ________ DOB: ____________

Vital Health
ENDOMETRIOSIS CENTER

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?
			☐ 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 4 5 6 7	0 1 2 3 4 5 6 7	V: C:		E: T:	0 1 2 3 4 5 6 7	M: SB: PT:	IUI IVF Clomid Other:

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

☐ Uterus	☐ Right Ovary	☐ Left Ovary	☐ Appendix	☐ Gallbladder
____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

How many days of each month are you unable to function normally? ____________

Patient Name: ______________________________

Date Form Completed: ________ DOB: ____________

Vital Health
ENDOMETRIOSIS
CENTER

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

Item	Scale
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**

Item	Scale
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**

Item	Scale
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

Item	Scale
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

Item	Scale
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

Item	Scale
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

____

____

____

____

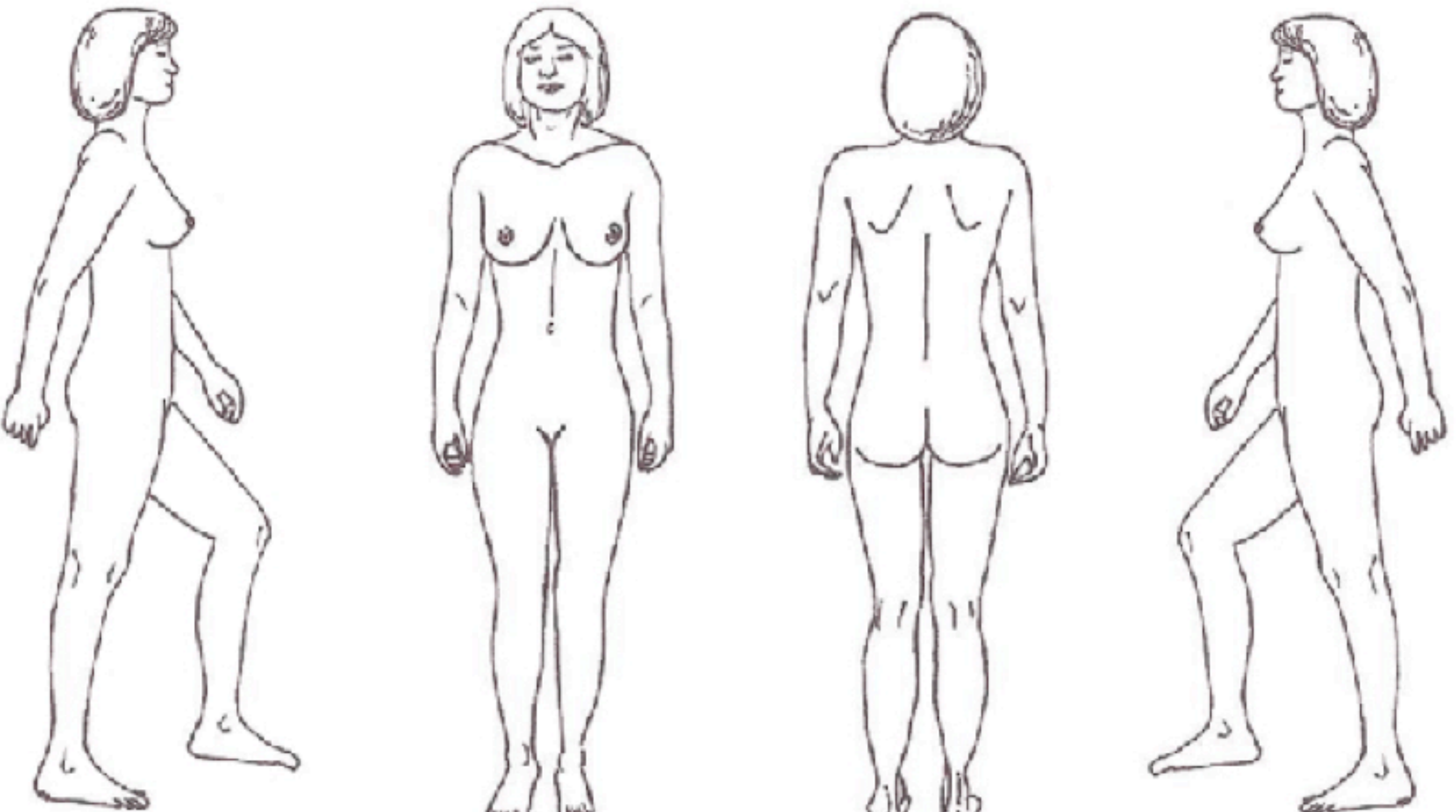
Patient Name: ______________________________

Date Form Completed: ________ DOB: ____________

Vital Health
ENDOMETRIOSIS
CENTER

Pain Map

Mark your areas of Pain

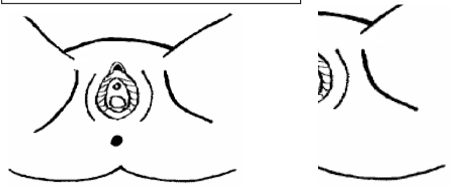


Vulvar / Perineal Pain
(pain outside and around the vagina and anus)

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

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

Right Left



Vulvar / Perineal Pair
(Pain outside and around the vagina a

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

Patient Name: ____________________________________

Date Form Completed: _________ DOB: _____________

Vital Health ENDOMETRIOSIS CENTER

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?

Patient Name: ______________________________

Date Form Completed: __________ DOB: ______________

Vital Health
ENDOMETRIOSIS CENTER

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)?

☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐

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*

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

CURRENT BOWEL/GASTROINTESTINAL SYMPTOMS

Check all that apply or ☐ *Check here if none apply*

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

Patient Name: ___________________________________

Date Form Completed: _________ DOB: _____________

Vital Health ENDOMETRIOSIS CENTER

PAST MEDICAL TREATMENTS OF PRESENT PROBLEM *Check all that apply, also circle those were helpful*

MEDICAL

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

PROCEDURES

☐ Nerve Blocks	☐ Cryo-ablation of nerve	☐ Implantable Devices	☐ Radiotherapy	☐ Other

SURGERY

☐ Removal of Endometriosis Date of Diagnosis: ____/____/____	☐ Bowel Resection Date: ____/____/____	☐ Hernia Repair Date: ____/____/____	☐ Removal of Scar Tissue Date: ____/____/____	☐ Other: ____/____/____

Classification of Endometriosis:

☐ Stage I (Minimal)	☐ Stage II (Mild)	☐ Stage III (Moderate)	☐ Stage IV (Severe)	☐Not Known

THERAPEUTIC

☐ Biofeedback	☐ Massage	☐ Physical Therapy	☐ Psychotherapy	☐ Chiropractic

LIFE STYLE CHANGES

☐ Diet/Nutrition	☐ Exercise	☐ Meditation	☐ Yoga	☐ Other

ALTERNATIVE

☐ Acupuncture	☐ Traditional Chinese Supplements	☐ Herbal Supplements	☐ Homeopathic	☐ Naturopathic

DIAGNOSTIC TESTS AND PROCEDURESS AND DATES PERFORMED: *CIRCLE ANY ABNORMAL LABS*

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

Patient Name: ________________________________

Date Form Completed: _________ DOB: ______________

Vital Health
ENDOMETRIOSIS
CENTER

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 to 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: _____________

Vital Health ENDOMETRIOSIS CENTER

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

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

Patient Name: ______________________________

Date Form Completed: __________ DOB: ______________

Vital Health ENDOMETRIOSIS CENTER

FAMILY HISTORY

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

1. ______ Allergies
2. ______ Alcoholism
3. ______ Asthma
4. ______ Auto Immune Disease
5. ______ Bleeding Disorder
6. ______ Depression
7. ______ Diabetes
8. ______ Endometriosis
9. ______ Epilepsy
10. ______ Fibromyalgia
11. ______ Gall Bladder Trouble
12. ______ Heart Disease
13. ______ High Blood Pressure
14. ______ Hypoglycemia
15. ______ IBS
16. ______ Kidney
17. ______ Lupus
18. ______ Stroke
19. ______ Thyroid
20. ______ Cancer

Type/s: ☐ Breast ☐ Ovarian ☐ Colon
Other:

SOCIAL HISTORY

Whom do you live with?	Were you ever the victim of sexual abuse as a child (<14 years old)? ☐ Yes ☐ No
Education:	Have you ever been a victim of physical abuse by a family member? ☐ Yes ☐ No
What work are you trained for:	Have you been a victim of emotional abuse? ☐ Yes ☐ No
What type of work are you doing:	Have you received therapy? ☐ Yes ☐ 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: ____________

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ENDOMETRIOSIS
CENTER

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: ____________

Vital Health
ENDOMETRIOSIS CENTER

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	Modera te	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					(37)

Patient Name: ______________________________

Date Form Completed: ________ DOB: ____________

Vital Health
ENDOMETRIOSIS CENTER

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	Occasio nally	Usually	Always			
	b.	If you are sexually active, has pain or urgency ever made you avoid sexual intercourse?	Never	Occasio nally	Usually	Always			
4	a.	Do you have pain associated with your bladder or in your pelvis, vagina, lower abdomen, urethra or perineum?	Never	Occasio nally	Usually	Always			
5	a.	Do you still have urgency shortly after urinating?	Never	Occasio nally	Usually	Always			
6	a.	When you have pain is it usually _____?	None	Mild	Moderate	Severe			
	b.	How often does your pain bother you?	Never	Occasio nally	Usually	Always			
7	a.	When you have urgency, is it usually ____?	None	Mild	Moderate	Severe			
	b.	How often does the urgency bother you?	Never	Occasio nally	Usually	Always			

SYMPTOM SCORE ______

BOTHER SCORE ______

TOTAL SCORE ______

Patient Name: ___________________________________

Date Form Completed: ________ DOB: _____________

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