Pelvic Pain Assessment Form

Initial History and Physical Examination
This assessment form is intended to assist the clinician with the initial patient assessment and is not meant to be a diagnostic tool.

<table>
<thead>
<tr>
<th>Contact Information</th>
<th>Birth Date:</th>
<th>Chart Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Home:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>Cell:</td>
<td></td>
</tr>
</tbody>
</table>

Information About Your Pain
Please describe your pain problem (use a separate sheet of paper if needed):

What do you think is causing your pain?

Is there an event that you associate with the onset of your pain? □ Yes □ No If so, what?

How long have you had this pain? ___ years ___ months

For each of the symptoms listed below, please "bubble in" your level of pain over the last month using a 10-point scale:
0 - no pain 10 – the worst pain imaginable

<table>
<thead>
<tr>
<th>How would you rate your pain?</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain at ovulation (mid-cycle)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pain just before period</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pain (not cramps) before period</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Deep pain with intercourse</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pain in groin when lifting</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pelvic pain lasting hours or days after intercourse</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pain when bladder is full</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Muscle / joint pain</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Level of cramps with period</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pain after period is over</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Burning vaginal pain after sex</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pain with urination</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Backache</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Migraine headache</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pain with sitting</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

Provider Comments

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(205) 877-2950 www.pelvicpain.org (800)624-9676 (if in the U.S.)
**Information About Your Pain**

What types of treatments/providers have you tried in the past for your pain?

- □ Acupuncture
- □ Anesthesiologist
- □ Anti-seizure medications
- □ Antidepressants
- □ Biofeedback
- □ Botox injection
- □ Contraceptive pills/patch/ring
- □ Danazol (Danocrine)
- □ Depo-provera
- □ Gastroenterologist
- □ Gynecologist
- □ Family Practitioner
- □ Herbal Medicine
- □ Homeopathic medicine
- □ Lupron, Synarel, Zoladex
- □ Massage
- □ Meditation
- □ Narcotics
- □ Naturopathic medication
- □ Nerve blocks
- □ Neurosurgeon
- □ Nonprescription medicine
- □ Nutrition/diet
- □ Physical Therapy
- □ Psychotherapy
- □ Psychiatrist
- □ Rheumatologist
- □ Skin magnets
- □ Surgery
- □ TENS unit
- □ Trigger point injections
- □ Urologist
- □ Other

**Please check all that apply.**

---

**Pain Maps**

Please shade areas of pain and write a number from 1 to 10 at the site(s) of pain. (10 = most severe pain imaginable)

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**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

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(205) 877-2950  www.pelvicpain.org  (800)624-9676 (if in the U.S.)
What physicians or health care providers have evaluated or treated you for **chronic pelvic pain**?

<table>
<thead>
<tr>
<th>Physician / Provider</th>
<th>Specialty</th>
<th>City, State, Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Demographic Information**

Are you (check all that apply):

- □ Married
- □ Widowed
- □ Separated
- □ Committed Relationship
- □ Single
- □ Remarried
- □ Divorced

Who do you live with? __________________________________________________________

Education:  
- □ Less than 12 years
- □ High School graduate
- □ College degree
- □ Postgraduate degree

What type of work are you trained for? ___________________________________________

What type of work are you doing? _______________________________________________

**Surgical History**

Please list all surgical procedures you have had related to this pain:

<table>
<thead>
<tr>
<th>Year</th>
<th>Procedure</th>
<th>Surgeon</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Please list all other surgical procedures:

<table>
<thead>
<tr>
<th>Year</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Provider Comments**

__________________________________________________________

__________________________________________________________
Medications

Please list **pain medication** you have taken for your pain condition in the past 6 months, and the providers who prescribed them (use a separate page if needed):

<table>
<thead>
<tr>
<th>Medication / dose</th>
<th>Provider</th>
<th>Did it help?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
</tbody>
</table>

Please list all **other medications** you are presently taking, the condition, and the provider who prescribed them (use a separate page if needed):

<table>
<thead>
<tr>
<th>Medication / dose</th>
<th>Provider</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Obstetrical History

How many pregnancies have you had? _______

Resulting in (#): _______ Full 9 months _______ Premature _______ Miscarriage / Abortion _______ Living children

Where there any complications during pregnancy, labor, delivery, or post partum?

☐ 4th Episiotomy ☐ C-Section ☐ Vacuum ☐ Post-partum hemorrhaging

☐ Vaginal laceration ☐ Forceps ☐ Medication for bleeding ☐ Other _______

Family History

Has anyone in your family had:

☐ Fibromyalgia ☐ Chronic pelvic pain ☐ Irritable bowel syndrome

☐ Depression ☐ Interstitial Cystitis ☐ Other Chronic Condition _______

☐ Endometriosis ☐ Cancer, Type(s) _______

Medical History

Please list any medical problems / diagnoses

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Allergies (including latex allergy) ________________________________

Who is your primary care provider? ________________________________

Have you ever been hospitalized for anything besides childbirth? ☐ Yes ☐ No If yes, please explain ________________________________

Have you had major accidents such as falls or a back injury? ☐ Yes ☐ No ________________________________

Have you ever been treated for depression? ☐ Yes ☐ No Treatments: ☐ Medication ☐ Hospitalization ☐ Psychotherapy ________________________________

Birth control method:

☐ Nothing ☐ Pill ☐ Vaseectomy ☐ Vaginal ring ☐ Depo provera

☐ Condom ☐ IUD ☐ Hysterectomy ☐ Diaphragm ☐ Tubal Sterilization ________________________________
### Menstrual History

**How old were you when your menses started?**

**Are you still having menstrual periods?** □ Yes □ No

**Answer the following only if you are still having menstrual periods.**

- **Periods are:** □ Light □ Moderate □ Heavy □ Bleed through protection
- **How many days between your periods?**
- **How many days of menstrual flow?**
- **Date of first day of last menstrual period**
- **Do you have any pain with your periods?** □ Yes □ No
- **Does pain start the day flow starts?** □ Yes □ No
- **Are periods regular?** □ Yes □ No
- **Do you pass clots in menstrual flow?** □ Yes □ No
- **Pain starts ____ days before flow**

### Gastrointestinal / Eating

- **Do you have nausea?** □ No □ With pain □ Taking medications □ With eating □ Other
- **Do you have vomiting?** □ No □ With pain □ Taking medications □ With eating □ Other
- **Have you ever had an eating disorder such as anorexia or bulimia?** □ Yes □ No
- **Are you experiencing rectal bleeding or blood in your stool?** □ Yes □ No
- **Do you have increased pain with bowel movements?** □ Yes □ No

*The following questions help to diagnose irritable bowel syndrome, a gastrointestinal condition, which may be a cause of pelvic pain.*

**Do you have pain or discomfort that is associated with the following:**

- Change in frequency of bowel movement □ Yes □ No
- Change in appearance of stool or bowel movement? □ Yes □ No
- Does your pain improve after completing a bowel movement? □ Yes □ No

### Health Habits

- **How often do you exercise?** □ Rarely □ 1-2 times weekly □ 3-5 times weekly □ Daily
- **What is your caffeine intake (number cups per day, include coffee, tea, soft drinks, etc)?** □ 0 □ 1-3 □ 4-6 □ >6
- **How many cigarettes do you smoke per day?** □ For how many years? □
- **Do you drink alcohol?** □ Yes □ No
- **Number of drinks per week** □
- **Have you ever received treatment for substance abuse?** □ Yes □ No
- **What is your use of recreational drugs?** □ Never used □ Used in the past, but not now □ Presently using □ No answer
  - □ Heroin □ Amphetamines □ Marijuana □ Barbiturates □ Cocaine □ Other □
- **How would you describe your diet?** (check all that apply) □ Well balanced □ Vegan □ Vegetarian □ Fried food □ Special diet □ Other □
**Urinary Symptoms:**

Do you experience any of the following?
- Loss of urine when coughing, sneezing, or laughing? □ Yes □ No
- Difficulty passing urine? □ Yes □ No
- Frequent bladder infections? □ Yes □ No
- Blood in the urine? □ Yes □ No
- Still feeling full after urination? □ Yes □ No
- Having to void again within minutes of voiding? □ Yes □ No

The following questions help to diagnose painful bladder syndrome, which may cause pelvic pain.

Please circle the answer that best describes your bladder function and symptoms.

<table>
<thead>
<tr>
<th>Question</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How many times do you go to the bathroom DURING THE DAY (to void or empty your bladder)?</td>
<td>3-6</td>
<td>7-10</td>
<td>11-14</td>
<td>15-19</td>
<td>20 or more</td>
</tr>
<tr>
<td>2. How many times do you go to the bathroom AT NIGHT (to void or empty your bladder)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 or more</td>
</tr>
<tr>
<td>3. If you get up at night to void or empty your bladder does it bother you?</td>
<td>Never</td>
<td>Mildly</td>
<td>Moderately</td>
<td>Severely</td>
<td></td>
</tr>
<tr>
<td>4. Are you sexually active? □ Yes □ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>6. If you have pain with intercourse, does it make you avoid sexual intercourse?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>7. Do you have pain associated with your bladder or in your pelvis (lower abdomen, labia, vagina, urethra, perineum)?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>8. Do you have urgency after voiding?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>9. If you have pain, is it usually</td>
<td>Never</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td></td>
</tr>
<tr>
<td>10. Does your pain bother you?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>11. If you have urgency, is it usually</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Does your urgency bother you?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
</tbody>
</table>

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KCI  □ Not Indicated  □ Positive  □ Negative
## Coping Mechanisms

Who are the people you talk to concerning your pain, or during stressful times?

- □ Spouse / Partner
- □ Relative
- □ Support group
- □ Clergy
- □ Doctor / Nurse
- □ Friend
- □ Mental Health provider
- □ I take care of myself

How does your partner deal with your pain?

- □ Doesn’t notice when I’m in pain
- □ Takes care of me
- □ Feels helpless
- □ Not applicable
- □ Withdraws
- □ Gets angry

What helps your pain?

- □ Meditation
- □ Relaxation
- □ Lying down
- □ Music
- □ Massage
- □ Ice
- □ Heating pad
- □ Hot bath
- □ Pain medication
- □ Laxatives / Enema
- □ Injection
- □ TENS unit
- □ Bowel movement
- □ Emptying bladder
- □ Nothing
- □ Other

What makes your pain worse?

- □ Intercourse
- □ Orgasm
- □ Stress
- □ Full meal
- □ Bowel movement
- □ Full bladder
- □ Urination
- □ Standing
- □ Walking
- □ Exercise
- □ Time of day
- □ Weather
- □ Contact with clothing
- □ Coughing / sneezing
- □ Not related to anything
- □ Other

Of all the problems or stresses of your life, how does your pain compare in importance?

- □ The most important problem
- □ Just one of many problems

---

## Sexual and Physical Abuse History

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted □ Yes □ No □ No answer

Check an answer for both as a child and as an adult.

1a. Has anyone ever exposed the sex organs of their body to you when you did not want it?
   - □ Yes □ No
   - □ Yes □ No

1b. Has anyone ever threatened to have sex with you when you did not want it?
   - □ Yes □ No
   - □ Yes □ No

1c. Has anyone ever touched the sex organs of your body when you did not want this?
   - □ Yes □ No
   - □ Yes □ No

1d. Has anyone ever made you touch the sex organs of their body when you did not want this?
   - □ Yes □ No
   - □ Yes □ No

1e. Has anyone forced you to have sex when you did not want this?
   - □ Yes □ No
   - □ Yes □ No

1f. Have you had any other unwanted sexual experiences not mentioned above?
   - □ Yes □ No
   - □ Yes □ No

If yes, please specify __________________________

2. When you were a child (13 or younger), did an older person do the following?
   a. Hit, kick, or beat you?
      - □ Never □ Seldom □ Occasionally □ Often
   b. Seriously threaten your life?
      - □ Never □ Seldom □ Occasionally □ Often

3. Now that you are an adult (14 or older), has any other adult done the following?
   a. Hit, kick, or beat you?
      - □ Never □ Seldom □ Occasionally □ Often
   b. Seriously threaten your life?
      - □ Never □ Seldom □ Occasionally □ Often


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**Short-Form McGill**

The words below describe average pain. Place a check mark (✓) in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of the pain in your pelvic area only.

<table>
<thead>
<tr>
<th>Type</th>
<th>None (0)</th>
<th>Mild (1)</th>
<th>Moderate (2)</th>
<th>Severe (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Throbbing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shooting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stabbing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharp</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cramping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gnawing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hot-Burning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aching</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heavy</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Tender</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Splitting</td>
<td></td>
<td></td>
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<tr>
<td>Tiring-Exhausting</td>
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<tr>
<td>Sickenning</td>
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<td>Fearful</td>
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<tr>
<td>Punishing-Cruel</td>
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**Pelvic Varicosity Pain Syndrome Questions**

- Is your pelvic pain aggravated by prolonged physical activity? □ Yes □ No
- Does your pelvic pain improve when you lie down? □ Yes □ No
- Do you have pain that is deep in the vagina or pelvis during sex? □ Yes □ No
- Do you have pelvic throbbing or aching after sex? □ Yes □ No
- Do you have pelvic pain that moves from side to side? □ Yes □ No
- Do you have sudden episodes of severe pelvic pain that come and go? □ Yes □ No
Physical Examination – For Physician Use Only

Name: ___________________________       Chart Number: ___________________________

Date of Exam: ____________________       Height: _______ Weight: _______ BMI: _______

BP: _______ HR: _______ Temp: _______ Resp: _______ LMP: _______

ROS, PFSH Reviewed: □ Yes □ No       Physician Signature: _________________________

General Appearance: □ Well-appearing □ Ill-appearing □ Tearful □ Depressed
□ Underweight □ Overweight □ Abnormal Gait

NOTE: Mark “Not Examined” as N/E

HEENT □ WNL □ Other

Lungs □ WNL □ Other

Heart □ WNL □ Other

Breasts □ WNL □ Other

Abdomen
□ Non-tender □ Tender □ Incisions □ Trigger Points
□ Inguinal Tenderness □ Inguinal Bulge □ Suprapubic Tenderness □ Ovarian Point Tenderness
□ Mass □ Guarding □ Rebound □ Distention
□ Other

Trigeminal Points
Right  Left  Right  Left

Surgical Scars
Right  Left  Right  Left

Other Findings

Back
□ Non-tender □ Tender □ Alteration in posture □ SI joint rotation

Lower Extremities
□ WNL □ Edema □ Varicosities □ Neuropathy □ Length Discrepancy

Neuropathy
□ Iliohypogastric □ Ilioinguinal □ Genitofemoral □ Pudendal □ Altered sensation

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(205) 877-2950 www.pelvicpain.org (800)624-9676 (if in the U.S.)
Fibromyalgia / Back / Buttock

External Genitalia

☐ WNL  ☐ Erythema  ☐ Discharge  ☐ Q-tip test (show on diagram)  ☐ Tenderness (show on diagram)

Q-tip Test (score each circle 0-4) Total Score

☐ WNL  ☐ Wet prep:
☐ Local tenderness  ☐ Vaginal mucosa  ☐ Discharge

Cultures: ☐ GC  ☐ Chlamydia  ☐ Fungal  ☐ Herpes
☐ Vaginal Apex Tenderness (post hysterectomy – show on diagram)

Transverse apex closure  Vertical apex closure

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Unimanual Exam
☐ WNL
☐ Introitus
☐ Uterine-cervical juncture
☐ Urethra
☐ Bladder
☐ R ureter
☐ R inguinal
☐ Muscle awareness
☐ Cervix
☐ Cervical motion
☐ Parametrium
☐ Vaginal cuff
☐ Cul-de-sac
☐ L ureter
☐ L inguinal
☐ Clitoral tenderness

Rank muscle tenderness on 0-4 scale
☐ R obturator
☐ L obturator
☐ L piriformis
☐ L pubococcygeus
☐ Anal Sphincter

Bimanual Exam
Uterus:
Position: ☐ Anterior
☐ Non-tender
☐ Posterior
☐ Other
☐ Midplane
Size: ☐ Normal
☐ Other
☐ Regular
☐ Irregular
☐ Other
☐ Soft
☐ Hard
Contour: ☐ Firm
☐ Other
☐ Regular
☐ Irregular
☐ Other
 ☐ Mobile
☐ Hypermobile
☐ Fixed
Mobility: ☐ Well supported
☐ Prolapse
Support: ☐ Fixed
☐ Enlarged cm
☐ Enlarged cm

Adnexal Exam
Right:
☐ Absent
☐ WNL
☐ Tender
☐ Fixed
☐ Enlarged cm
Left:
☐ Absent
☐ WNL
☐ Tender
☐ Fixed
☐ Enlarged cm

Rectovaginal Exam
☐ WNL
☐ Tenderness
☐ Nodules
☐ Mucosal pathology
☐ Guaiac positive
☐ Not examined

Assessment:

Diagnostic Plan:

Therapeutic Plan: