The Echenberg Institute
for pelvic & sexual pain

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Please complete this questionnaire in its entirety, even if you feel some sections do not apply to you.

INITIAL MALE PELVIC PAIN QUESTIONNAIRE

Patient Information Date: _____

Name: _____ DOB: _____ Age: _____

Race/Ethnic Identity: _____

Sexual Orientation: ___Heterosexual ___Homosexual ___Bisexual ___Asexual ___Other: _____

Religious/Spiritual Affiliation (optional): _____

Medication Allergies: _____

(Office use: G P A VIP LC____ Drive time: _____ Wgt_____ BP_____)

Demographic Information

1. **Are you (circle all that apply):**
   Single Married (____ years) Separated Divorced
   Widowed Committed Relationship (____years) Remarried

2. **Education:**
   Less than 12 years High School graduate Technical School
   College degree Post-graduate degree

3. Who do you live with? _____
4. What type of work are you trained for? _____
5. What type of work are you doing? _____
6. What type of work does your partner do? _____
7. Has pain forced you to give up or change your type of work? ____ Yes ____ No

8. **If yes, how has pain changed your work?**
   a. Changed to a less strenuous, but full-time job? ____Yes ____ No
   b. Changed to part-time work? ____Yes ____ No
   c. Unable to work? ____Yes ____ No
   d. If disabled, how long have you been unable to work? _____

Family History

9. **List anyone in your family**, *including relatives, (excluding yourself)* **who have had;**

- ❑ Fibromyalgia
- ❑ Endometriosis
- ❑ Depression/Anxiety
- ❑ Chronic pelvic pain
- ❑ Migraine headaches
- ❑ Cancer (type)
- ❑ Irritable bowel syndrome
- ❑ Interstitial Cystitis

Other: _____

_____

10. Please describe your pain problem

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

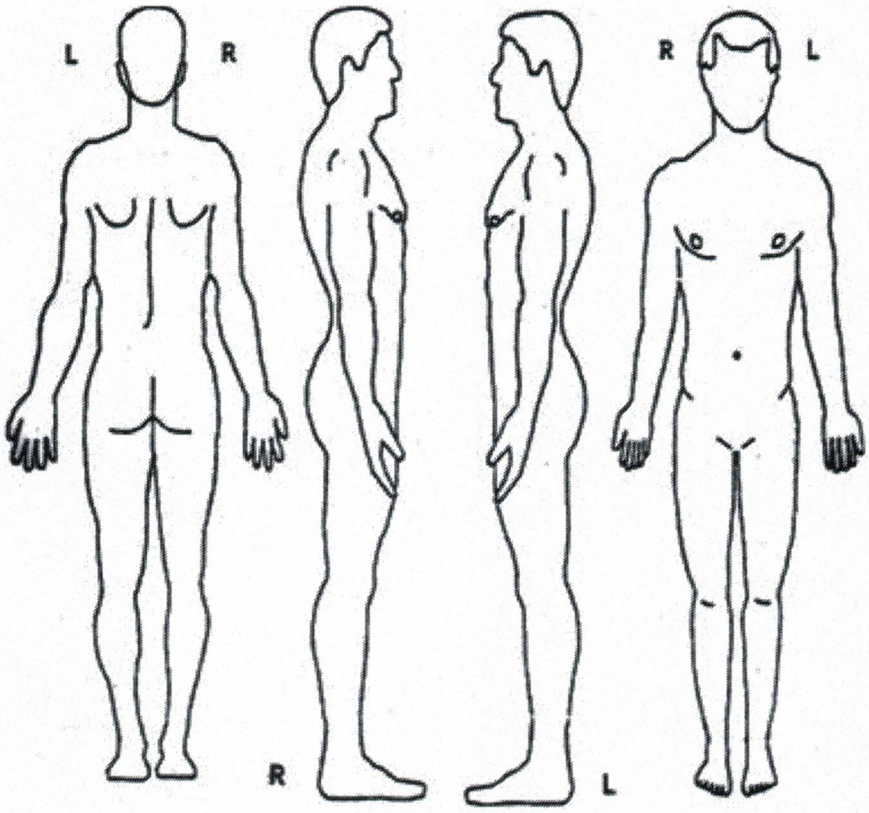
_____

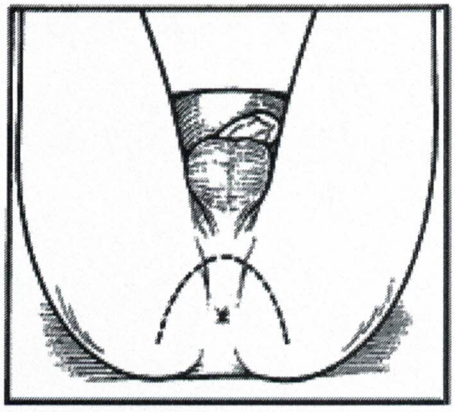
Groin pain? Yes___ No ___
Abdominal Pain? Yes ___ No ___
Lower back pain? Yes ___ No ___
Pain with sitting? Yes___ No ___

Dates (years only) of Ultrasound: _____
MRI: _____
CT Scan: _____

ANSWER ALL QUESTIONS AS IF YOU'RE HAVING YOUR MOST SEVERE DAY OF PAIN

On the diagrams below, shade in <u>all the areas of your body where you feel pain</u>.
If there is an area that hurts more than anywhere else, put an *X* on that area.



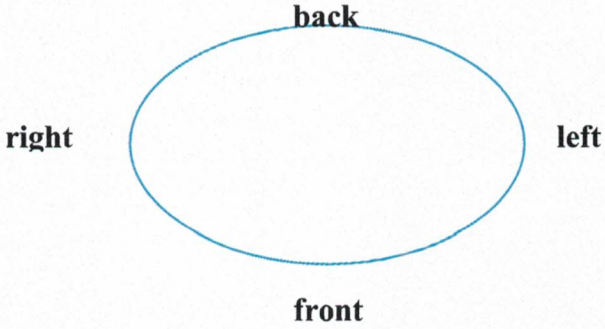


Perineal Pain
(pain outside and around the scrotrum and rectum)

If you have perineal pain, shade the painful areas.

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

Then shade the inside view of the pelvis to show pain that is deep.



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):

Medication/dose	Provider	Did it help?
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking

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

Medication/dose	Provider	Medical Condition

11. **Your age when you first started having pain:** _____
12. **If your pain had gone away and now has returned, what age did it return?** _____
13. **What do you think is causing your pain?** _____
14. **Is there an event that you associate with the onset of your pain?** Yes No
    If yes, what? _____
15. **How long have you had this pain?** _____ years _____ months
16. **Please tell us how the pain started or the circumstances related to its onset:**
    _____
    _____
17. **How has the intensity of your pain changed over the past several months?**
    ☐ Increased ☐ Decreased ☐ Stayed the same ☐ Varied

18. Which word or words would you use to describe the pattern of your pain?
(Circle all that apply)

Continuous	Rhythmic	Brief
Steady	Periodic	Momentary
Constant	Intermittent	Transient

19. Shade in the circle of the number that most appropriately rates your pain level:

0 = No Pain 10 = Worst Possible Pain

		0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
a.	Right now	O	O	O	O	O	O	O	O	O	O	O
b.	At its worst in the past month	O	O	O	O	O	O	O	O	O	O	O
c.	At its least in the past month	O	O	O	O	O	O	O	O	O	O	O
d.	At its average in the past month	O	O	O	O	O	O	O	O	O	O	O
e.	With intercourse	O	O	O	O	O	O	O	O	O	O	O
f.	Entrance pain	O	O	O	O	O	O	O	O	O	O	O
g.	Pain or burning following intercourse	O	O	O	O	O	O	O	O	O	O	O
h.	Pain with sitting	O	O	O	O	O	O	O	O	O	O	O
i.	Pain in either groin	O	O	O	O	O	O	O	O	O	O	O
j.	Worst toothache ever	O	O	O	O	O	O	O	O	O	O	O
k.	Worst headache ever	O	O	O	O	O	O	O	O	O	O	O
l.	Ideal acceptable level of pain?	O	O	O	O	O	O	O	O	O	O	O

20. What does your pain feel like?
(The words below describe average pain. **Please shade the circles in the correct 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.*)

	None (O)	**Mild (1)**	**Moderate (2)**	**Severe (3)**
Throbbing	O	O	O	O
Shooting	O	O	O	O
Stabbing	O	O	O	O
Sharp	O	O	O	O
Cramping	O	O	O	O
Gnawing	O	O	O	O
Hot-Burning	O	O	O	O
Aching	O	O	O	O
Heavy	O	O	O	O
Tender	O	O	O	O
Splitting	O	O	O	O
Exhausting	O	O	O	O
Sickening	O	O	O	O
Fearful	O	O	O	O
Punishing/Cruel	O	O	O	O

PLEASE REMEMBER TO CONTINUE TO ANSWER ALL QUESTIONS AS IF YOU'RE HAVING YOUR MOST SEVERE DAY OF PAIN.

21. Please shade the number that describes how, during the past month, pain has interfered with:

(0 = did not interfere 10 = completely interfered)

	0	1	2	3	4	5	6	7	8	9	10
a. General Activity	O	O	O	O	O	O	O	O	O	O	O
b. Housework	O	O	O	O	O	O	O	O	O	O	O
c. Walking	O	O	O	O	O	O	O	O	O	O	O
d. Sleeping	O	O	O	O	O	O	O	O	O	O	O
e. Enjoyment of Life	O	O	O	O	O	O	O	O	O	O	O
f. Mood	O	O	O	O	O	O	O	O	O	O	O
g. Relations with Other People	O	O	O	O	O	O	O	O	O	O	O
h. Sexual Relations	O	O	O	O	O	O	O	O	O	O	O

22. Mark the number that summarizes your overall sense of well-being for the past month.
(When reflecting on your sense of well-being over the past month, you need to take into consideration your physical, mental, emotional, social and spiritual condition.)

0 = worst you have ever been 10 = best you have ever been

0 1 2 3 4 5 6 7 8 9 10

23. Who are the people you talk to concerning your pain or during a stressful time?

- ❑ Spouse/Partner
- ❑ Friend
- ❑ Doctor/Nurse
- ❑ Relative
- ❑ Support Group
- ❑ Mental Health Provider
- ❑ Clergy
- ❑ I take care of Myself

24. How does your partner deal with your pain?

- ❑ Doesn't notice when I'm in pain
- ❑ Withdraws
- ❑ Distracts me with activities
- ❑ Takes care of me
- ❑ Feels helpless
- ❑ Gets angry
- ❑ Not applicable

25. What helps your pain?

- ❑ Meditation
- ❑ Massage
- ❑ Injection
- ❑ Laxatives
- ❑ Relaxation
- ❑ Ice
- ❑ Pain Medication
- ❑ Emptying Bladder
- ❑ Lying down
- ❑ Heating Pad
- ❑ TENS Unit
- ❑ Music
- ❑ Hot Bath
- ❑ Nothing
- ❑ Prayer
- ☐ Other:_____

26. What makes your pain worse?

- ❑ Intercourse
- ❑ Bowel Movement
- ❑ Walking
- ❑ Clothing Contact
- ❑ Orgasm
- ❑ Full Bladder
- ❑ Exercise
- ❑ Coughing/Sneezing
- ❑ Stress
- ❑ Urination
- ❑ Time of Day
- ❑ Weather
- ❑ Full Meal
- ❑ Standing
- ❑ Sitting
- ❑ Not Related to Anything

27. Of all the problems or stresses of your life, how does your pain compare?

- ❑ The most important
- ❑ Just one of many problems

28. What types of treatment/providers have you tried in the past for your pain?

❑ Acupuncture	❑ Family practitioner	❑ Nutrition/diet
❑ Anesthesiologist	❑ Herbal medicine	❑ Physical therapy
❑ Anti-seizure medications	❑ Homeopathic medicine	❑ Psychotherapy
❑ Antidepressants	❑ Lupron, Synarel, Zoladex	❑ Psychiatrist
❑ Biofeedback	❑ Massage therapy	❑ Rheumatologist
❑ Bladder Instillations	❑ Meditation	❑ Skin magnets
❑ Botox injections	❑ Narcotics	❑ Surgery
❑ Contraceptive methods	❑ Naturopathic medication	❑ TENS unit
❑ Danazol (Danocrine)	❑ Nerve blocks	❑ Trigger point injections
❑ Depo-Provera	❑ Neurosurgeon	❑ Urologist
❑ Gastroenterologist	❑ Nonprescription medications	❑ Pain Management
❑ Gynecologist	❑ Other _____	❑ Other_____

29. Approximately how many health care practitioners have you seen up until this point for your pelvic pain symptoms? _____

29a. Have any of the following providers either told you or implied that your pain is "all in your head"?

i) Healthcare Practitioner ___
ii) Family member ___
iii) Sexual partner ___
iv) Friend ___
v) Co-worker ___
vi) Classmate ___
vii) Yourself ___

29b. What is the worst thing any doctor has told you about your pain?

29c. Indicate to us the top 3 people in your life who <u>believe</u> the level of pain you have been experiencing. (Eg: partner, family, friend, doctor)

29d. Who in your life helps you feel safe?

29. What physicians or health care providers have evaluated you for chronic pelvic pain?

Physician/Provider *Specialty* *City, State* *Phone Number*

a. _____

b. _____

c. _____

d. _____

e. _____

Health Habits

30. How often do you exercise? ❑ Rarely ❑ 1-2x weekly ❑ 3-5x weekly ❑ Daily

31. What is your caffeine intake? ❑ 0 ❑ 1-3 ❑ 4-6 ❑ 6+
(number of cups per day including coffee, tea, soft drinks, etc.)

32. How many cigarettes do you smoke per day? _____ For how many years? _____
33. Do you drink alcohol? _____Yes _____No Number of drinks per week? _____

34. Have you ever received treatment for substance abuse? _____Yes _____No
35. What is your use of recreational drugs?

❑ Never used ❑ Used in past, but not now ❑ Presently using
❑ Marijuana ❑ Cocaine ❑ Barbiturates ❑ Amphetamine ❑ Heroin ❑ Other

Gastrointestinal/Eating

36. Do you have nausea? ❑ No ❑ With pain ❑ Taking medications ❑ With eating
37. Do you have vomiting? ❑ No ❑ With pain ❑ Taking medications ❑ With eating

38. How would you best describe your diet?
❑ Well-balanced ❑ Vegan ❑ Vegetarian ❑ Fried food

39. Have you ever had an eating disorder such as anorexia or bulimia? _____ Yes _____No
40. Are you experiencing rectal bleeding or blood in your stool? _____Yes _____No
41. 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 chronic pelvic pain.

42. 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

Lower Bowel Symptoms

34. Have you had a colonoscopy? ____ Yes ____ No *If yes, when?* _____

35. In general have you had?:

		Yes	**No**
a.	Less than 3 bowel movements per week	O	O
b.	More than 3 bowel movements per day	O	O
c.	Hard or lumpy stools	O	O
d.	Loose or watery stools	O	O
e.	Straining during a bowel movement	O	O
f.	Urgent need to have a bowel movement	O	O
g.	Feeling of incomplete emptying with bowel movements	O	O
h.	Passing mucous at the time of bowel movements	O	O
i.	Abdominal fullness, bloating or swelling	O	O
j.	Pain with bowel movement	O	O
k.	Pain relieved with bowel movement	O	O

Urinary Symptoms

45. Have you had a cystoscopy? _____Yes _____No *If yes, when?* _____

46. 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
If you took a long car ride (2-4 hours) would you have to make a stop to use the bathroom?	❑ Yes	❑ No

"Urinary urgency" is defined as a compelling desire to urinate, which is difficult to postpone because of pain, pressure or discomfort and a fear of worsening pain.

Please circle the answer that best describes your bladder function and symptoms, as if you are having a BAD day with your bladder.

	0	1	2	3	4
How many times do you go to the bathroom DURING THE DAY (to void or empty your bladder?)	3-6	7-10	11-14	15-19	20 or more
How many times do you go to the bathroom AT NIGHT (to void or empty your bladder?)	0	1	2	3	4 or more
If you get up at night to void or empty your bladder, does it bother you?	Never	Mildly	Moderately	Severely	
Do you have the urge to go again soon after voiding?	Never	Occasionally	Usually	Always	
If you have urgency *(see definition above)* is it usually:	Never	Mild	Moderate	Severe	
Does your urgency bother you?	Never	Occasionally	Usually	Always	
Do you have pain associated with your bladder OR in your pelvis (lower abdomen, labia, vagina, urethra or rectum?)	Never	Occasionally	Usually	Always	
If you have pelvic pain , is it usually:		Mild	Moderate	Severe	
Are you sexually active? ***If no, is it because of pain?**	Yes Yes	No* No			
If you are or have been sexually active do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always	
Does your pain bother you?	Never	Occasionally	Usually	Always	

Office use:

Sexual Pain History

47. Have you ever been sexually active? _____Yes _____No

If yes, please answering the following:

Have you been sexually active in the past 6 months? _____Yes _____No

Number of lifetime sexual partners (approximate): _____

Age at first intercourse: _____

Any pain during or after orgasm? _____Yes _____No

48. If pain or discomfort with sexual activity if part of your pelvic pain problem…:

a. Pain with first sexual experience?	❑ Yes	❑ No
b. Only with current partner?	❑ Yes	❑ No
c. Also with previous partner?	❑ Yes	❑ No
d. Is your current partner always aware of your pain or discomfort?	❑ Yes	❑ No
e. Erectile dysfunction	❑ Yes	❑ No
f. Rapid ejaculation	❑ Yes	❑ No
g. Low sexual desire	❑ Yes	❑ No

Describe current sexual pain or discomfort and how it is affecting your relationship:

_____

_____

49. Does your partner have sexual difficulty? _____Yes _____No _____Uncertain

If yes, please shade all that apply: O Low sexual desire O Fear of hurting

O Genital or Sexual pain O Other: _____

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

50. **Check an answer for both as a child and as an adult:**	As a child (13 and younger)		As an adult (14 and older)	
a. Has anyone ever exposed the sex organs of their body to you when you did not want it?	❑ Yes	❑ No	❑ Yes	❑ No
b. Has anyone ever threatened to have sex with you when you did not want it?	❑ Yes	❑ No	❑ Yes	❑ No
c. Has anyone ever touched the sex organs of your body when you did not want this?	❑ Yes	❑ No	❑ Yes	❑ No
d. Has anyone ever made you touch the sex organs of their body when you did not want this?	❑ Yes	❑ No	❑ Yes	❑ No
e. Has anyone forced you to have sex when you did not want this?	❑ Yes	❑ No	❑ Yes	❑ No
f. Have you had any other unwanted sexual experiences not mentioned above?	❑ Yes	❑ No	❑ Yes	❑ No

51. **When you were a child did an older person ever hit, kick or beat you? Threaten your life?**

_____*Yes* _____ *No* O Never O Seldom O Occasionally O Often

52. **Now that you are an adult, has another adult ever hit, kick or beat you? Threaten your life?**

_____*Yes* _____*No* O Never O Seldom O Occasionally O Often

Headache History

53. Do you have a history of headaches? _____ Yes _____ No

If yes, when did they begin? _____

What is the frequency of your headaches? _____

Do you suffer from migraine headaches? _____Yes _____No

What do you take for your headaches? _____

Sleep Problems

54. Do you have trouble falling asleep? o Yes o No
55. Do you have trouble staying asleep? o Yes o No
56. Do you take anything to help you sleep? o Yes o No

Seasonal Allergies

57. Do you have seasonal allergies? o Yes o No
    If yes, allergic to:
    _____
58. Do you take anything for your allergies? o Yes o No
    If yes, what do you take:
    _____

Surgical History

59. Please list all surgical procedures you have had *(related to your pain):*

Procedure	Surgeon	Year	Findings

60. Please list all surgical procedures you have had *(not related to your pain):*

Procedure	Surgeon	Year	Findings

Medical History

61. Please list any other medical problems/diagnoses:

_____
_____
_____
_____

62. Have you ever been hospitalized for anything other than surgeries?
_____Yes _____ No *If yes, please explain:*

_____
_____

62a. **Approximately how many times have you gone to an emergency room because of your pelvic pain symptoms?** _____

Physical Trauma History

63. Through your entire life, have you had any painful injuries, torn ligaments, whiplash, straddle injuries, tailbone injuries, concussions or broken bones, including ALL parts of your body? If you can't remember, please ask a family member. _____No _____ Yes
If yes, please explain:

_____
_____
_____

Have you ever been in a car accident? ___No ___ Yes. If yes, please explain:

_____
_____
_____

64. Please list all major physical activities and/or sports you have participated in competitively or recreationally and how many years of each. *(This includes gymnastics, cheerleading, dance, horseback riding, soccer, softball, volleyball, track & field, running, etc)*

Activity or Sport	Years of Participation

Significant Emotional Stressors

65. In general, how would you describe your current relationship?	No tension Some tension A lot of tension
66. Do you and your current partner work out arguments with:	A lot of difficulty Some difficulty No difficulty
67. Do arguments ever result in you feeling down or bad about yourself?	Often Sometimes Never
68. Do you ever feel frightened by what your current partner says or does?	Often Sometimes Never
69. Has your current partner ever abused you emotionally?	Often Sometimes Never
70. Has your current partner ever abused you sexually?	Often Sometimes Never

Please clearly circle the answer that best suits your situation

71. What other important stressors in your life should we know about? Please explain.

72. How does your pelvic pain problem affect your life?

73. What is the pain preventing you from doing?

74. What is your greatest fear regarding your pelvic pain symptoms?

75. Do your symptoms cause you more pain or suffering? Please explain

76. ***Please feel free to share any more information about your pain that you feel we need to know.***