PNK sleeth + DASS-21
SE.

Thankyou for taking the time to fill out these forms. This provides Dr Evans with valuable information and allows more time to discuss the things most important to you during your visit with us. Please bring these forms with you to your appointment.

Name_____Date of birth_____

Postal Address_____

_____ Postcode_____

Email address:_____

Telephone: Home:_____Work:_____Mobile:_____

Occupation:(optional)_____

Alternative contact person_____

Relationship_____Phone_____

Private health insurance? Yes/ No/ Extras only Date of joining .....

** Please notify us if you have been in your fund for less than 1 year. This is important as you will not be able to claim hospital expenses from your health fund if your waiting period is incomplete.

Name of fund_____Membership no_____

Referring doctor_____

Medicare number_____Your numbered position_____
(on the card to the left of your name)

Expiry date_____

The provision of quality health care requires a doctor-patient relationship of trust and confidentiality. We regard patient health information as confidential and will only collect this information with your consent. A copy of our privacy policy is available on request. I consent to the collection and use of personal health information by this practice in accordance with privacy legislation.

Signed_____Date_____

Dr Evans is actively involved in teaching other health professionals about the management of pelvic pain. On some days Dr Evans may have another health professional sitting in with her observing your consultation and examination. They are observers only and not involved in decisions about your health care. If you would be uncomfortable having another health professional present, please contact us well before the day of your appointment and we will ensure that you are seen on a day when we do not have an observer.

I understand that it is possible that an observer may be present at my consultation.

Signed_____Date_____

PTO

If you have pelvic pain, you can learn more and start to manage your pain before your visit by:

- reading the free e-Booklet at **www.pelvicpainsa.com.au/free-e-booklet**.
- visiting the Pelvic Pain Foundation of Australia website at www.pelvicpain.org.au and reading the information there, or attending PPFA events

Before your visit to Dr Evans we ask that you answer the questions on this sheet. They help us understand your concerns better and allow us more time at your visit to discuss the issues most important to you.

For some of the questions we have asked you to tell us 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.

Firstly, what is the problem that bothers *you* the most?

_____
_____
_____
_____
_____
_____
_____

You and your pain

1. Your age _____

2. Do you have period pain, pelvic pain, or both, or no pain? (circle the correct answer)

I have pain with periods, *but no other pelvic pain*
I have pain with periods, *and pelvic pain at other times of the month*
I have pelvic pain during the month, *but it is no worse with periods*
I have no pelvic or period pain
Other_____

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

4. 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 3 and Q 4 should add up to 30)

5. How much pain do you have today (the day you are completing this form)?

Pain Score (0-10) _____

Your Operations

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

_____Year_____
_____Year_____
_____Year_____
_____Year_____
_____Year_____
_____Year_____
_____Year_____

Your Medications

7. 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		

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

Medications I use with periods

_____
_____
_____

Medications I use every day

_____
_____
_____

Medications I use occasionally

_____
_____
_____

9. Do you have any allergies? Yes / No

_____

Your Periods

10. How old were you when your periods started? _____

11. Do you have period pain? Yes / No / Occasionally Pain Score (0-10)_____

If so,
How old were you when your periods became painful? _____

For how many days each month do you have period pain? _____

Where do you feel your period pain? (circle as many as apply)

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
Another place _____

Does the contraceptive pill help your period pain? (circle)

Yes, a lot / a little / not at all /
I have never tried the pill / My period pain started when I stopped taking 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

12. When was the first day of your last (or current) period? _____

13. How long between the first day of one period and first day of your next period? _____

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

Stabbing pains in your abdomen

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

Yes / No / Occasionally Pain Score (0-10) _____

If so,

How old were you when these pains started? _____

Where do you feel these pains? (circle as many as apply)

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

Another place _____

Do any exercises or movements make these pains worse?

Yes / No _____

Do any exercises or movements make these pains better?

Yes / No _____

What exercise do you do?

_____

Your Bowel

16. 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

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

If so, which foods don't suit you?

Wheat	Yes / No
Dairy foods	Yes / No
Fatty foods	Yes / No
Other foods	_____
Food Allergies	_____

Your Bladder

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

While awake? _____

At night, after going to sleep? _____

19. Do you have problems with your bladder? Yes / No / Occasionally / Only with periods

If so, At what age did these bladder problems start? _____

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

I can wait until later / I need to pass urine straight away

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

Pain Score (0-10) ____

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

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

How much fluid do you drink each day? _____

Headaches

20. 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 / Every period / Some periods
Pain Score (0-10) _____

Do you get bad headaches or migraines at other times? Yes / No / Occasionally
Pain Score (0-10) _____

Do you get milder background headaches at other times? Yes / No / Occasionally
Pain Score (0-10) _____

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

22. How many days a month do you have a headache, even a mild headache? _____

23. How many days a month are you completely free of headache (no headache at all)? _____

(Please note that the answers to questions 22 and 23 should add up to 30)

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

24. Do you have vulval pain? Yes / No Pain Score (0-10) _____

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

Anytime / with intercourse / using tampons / only with a vaginal infection or thrush

Your Sexual Wellbeing

Please note that questions 26 to 31 are optional and may not apply to all girls or women.

26. Are you currently or have you ever been in a sexual relationship?

Yes / No / I prefer not to answer this question

If so,
Do you feel pain or discomfort during sexual activity? Yes / No / Occasionally

Pain Score (0-10) _____

When do you get this pain? (please circle as many as apply)

With arousal / during intercourse / after intercourse / The day after intercourse

At what age did intercourse become painful? _____

Have you experienced distressing sexual events during your life, including sexual assault?

Yes / No / I prefer not to answer this question / I would like to discuss this during my appointment with Dr Evans / I prefer *not* to discuss this during my appointment

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 Autoimmune 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)

_____

_____

Pain conditions as a child

33. Did you have any pain conditions as a child, before you started your periods? Yes / No

If so, were these:

Headaches	Yes / No	
Abdominal pain	Yes / No	
Growing pains	Yes / No	
Arthritis	Yes / No	
Others	Yes / No	Please describe_____

Your Family History

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

Migraine Headaches	Yes / No
Long term pain condition	Yes / No
Endometriosis	Yes / No
Thyroid disease	Yes / No
Coeliac Disease	Yes / No
Ulcerative Collitis or Crohns Disease	Yes / No
Rheumatoid Arthritis or SLE	Yes / No

Your Mood

Pain of any kind can be aggravated by stress, anxiety or depression. The last sheet of this questionnaire asks about your mood.

Other Health Issues

Are there any other health issues you believe we should know about?

_____

It is possible that we may wish to use this data anonymously in the future for research purposes. We will only do this with your consent. Please note that the sheet with your personal details would be removed from this record and you would not be identified in any way. (please tick a box)

Yes, I agree to this information being used anonymously for research ☐
No, I do not agree to this information being used anonymously for research ☐

Thank you very much for taking the time to complete this questionnaire. We look forward to seeing you at your visit and hope to make a real difference to your pain.

DASS21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3