DR PHILIP HALL

MBBS MRMed FRANZCOG FROCG FACRRM

Thank you for taking the time to fill out this form, it provides Dr Hall with valuable information and allows more time to discuss the things most important to you during your visit. Please bring this form with you to your appointment.

Today's Date.....

Name..... Age..... Date of Birth.....

Address.....

.....

Email address.....

Telephone Home..... Mobile.....

Occupation.....

Alternative contact person.....

Relationship..... Mobile.....

Private health insurance? Yes/ No/ Extras only (please circle) 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 number.....

Referring doctor.....

Medicare number..... Your numbered position..... (on the card to the left of your name)

Expiry date.....

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

- Visiting Dr Hall's website www.pelvicmed.com.au
- Visiting the Pelvic Pain Foundation of Australia website www.pelvicpain.org.au and reading the information there.

Before your visit to Dr Hall, we ask that you complete this short questionnaire. This information helps us to better understand your concerns and allows us more time during 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 or tick the answer that best describes your pain.

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?

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You and your pain

1. Do you have period pain, pelvic pain, or both, or no pain? (tick correct answer below)

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.....

2. How many days over an average month would you have pelvic pain or discomfort of any kind, even mild pain?.....

3. How many days over an average month would you be entirely well with no pelvic discomfort at all? .....

4. What is your pain score today (1–10).....

Your previous operations

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

- ..... Year.....
- ..... Year.....
- ..... Year.....
- ..... Year.....
- ..... Year.....

Your medications

6. Are you currently using any of these hormonal medications? (circle)

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

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

Medications I use with periods

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.....

.....

Medications I use every day

.....

.....

.....

Medications I use occasionally

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8. Do you have any allergies? Yes / No

9. If Yes, please provide information.....

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 you answered Yes or Occasionally:

- 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?

  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 you answered Yes or Occasionally:

- How old were you when these pains started?.....
- Where do you feel these pains? (circle as many that 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 Examples.....

- Do any exercises or movements make these pains better?

  Yes / No Examples.....

- What exercise do you do?.....

Your bowel

16. Do you have problems with your bowel? Yes / No / Occasionally

If you answered Yes or Occasionally:

- How old were you when your bowel problems started?.....
- Do you have constipation? Yes / No / Occasionally / Only with periods
- Do you have diarrhoea? Yes / No / Occasionally / Only with periods
- Do you feel bloated? Yes / No / Occasionally / 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 you answered Yes, *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 you answered Yes or Occasionally:

- 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 you answered Yes or Occasionally:

- 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)?.....

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 you answered Yes:

- 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

26. Are you currently or have you ever been in a sexual relationship? Yes / No

If you answered Yes:

- 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 / 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? Yes / No How many?.....

29. Are you currently trying to become pregnant? Yes / No

If you answered No, 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)

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.....

Pain conditions as a child

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

If you answered Yes, were these:

Headaches	Yes / No	
Abdominal pain	Yes / No	
Growing pains	Yes / No	
Arthritis	Yes / No	
Other	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 page of this questionnaire asks about your mood, it's called the DASS21 test.

Other Health Issues

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

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I consent to the collection and administrative use of my personal health information by this practice in accordance with privacy legislation.

Signature..... Date.....

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