FUPS 002. 08.26.2021

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* **This form will take less than *10 minutes* to complete. Please take your time, answer the questions as completely as you can.**
* **You can complete this form electronically or with pen and paper.**
* **When you are done, give the form to your clinician or a member of your healthcare team.**
* [**IMPORTANT PRIVACY AND SECURITY NOTICE:**The questionnaires below are collect private health information (PHI). DO NOT mail, fax, or email them to clinicians and other persons, unless these modes of communication are equipped with encryption and security measures designed to transfer private health information.](https://b43671ae-17b3-4c94-a509-94216e51bc3f.filesusr.com/ugd/8f46f9_879c015342604627a5c69d6213091ba2.docx?dn=Health%20Care%20Professional%20INITIAL%20Assessm)

**FOLLOW UP PATIENT SURVEY**

***PLEASE TELL US HOW YOU ARE DOING SINCE YOUR LAST VISIT.***

1. **Since your last visit, have you been diagnosed with any NEW MEDICAL PROBLEMS?**

[ ] No [ ] Yes, select all that apply from the list below:

[ ] Endometriosis [ ] Fibromyalgia [ ] Chronic pelvic pain

[ ] Irritable bowel syndrome [ ]  Interstitial Cystitis [ ] Colon Cancer [ ] Breast Cancer

[ ] Uterine Cancer [ ] Ovarian Cancer [ ] Depression [ ] Chronic Fatigue Syndrome

[ ]  Anxiety/Panic Attacks [ ] Temporomandibular Joint Disorder [ ] Migraine Headache [ ] Post-Traumatic Stress Disorder (PTSD)

 [ ] OtherClick or tap here to enter text.

1. **Since your last visit have you had any NEW SURGERIES?**

[ ] No [ ] Yes, please describe here:Click or tap here to enter text.

1. ***If* you had PAIN symptoms before, how would you describe your PAIN symptoms now?**

[ ] Much better

[ ] Better

[ ] About the same

[ ] Worse

[ ] Much worse

[ ] I did not have any pain symptoms compared to before.

1. **On a scale from 0% (not improved at all) to 100% (completely better), how would you rate the change in your PAIN symptoms?** Click or tap here to enter text. **%**
2. **In the last 30-60 days, or since your last visit with us, how many times have you been to the Emergency Room to get treated for this pain?**

[ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 [ ] 11 or more times

1. **Compared with before receiving treatment from us, how would you describe yourself now *overall*?**

Patient global impression of severity

[ ] Much better [ ]  Better [ ] About the same [ ] Worse [ ] Much worse

1. **If you are being treated for pain, which statement best describes your pain? *(Check only one)***

[ ] Always present (always the same intensity)

[ ] Always present (level of pain varies)

[ ] Often present (pain free periods less than 6 hours)

[ ] Occasionally present (once to several times per day lasting up to an hour)

[ ] Rarely present (pain occurs every few days or weeks)

1. **Rate the SEVERITY OF YOUR PAIN (*YOUR WORSE OR MAIN PAINFUL AREA*) on the scales below:**

|  |
| --- |
| [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |

 **No Pain Worse imaginable pain**

|  |
| --- |
| In the past *7 days….* |
|  | **Had no pain** | **Mild** | **Moderate** | **Severe** | **Very severe** |
| 1. How intense was your pain at its worse? | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 | [ ] 5 |
| 2. How intense was your average pain? | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 | [ ] 5 |
| 3. What is your level of pain right now? | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 | [ ] 5 |

Pain Intensity Scale Short Form 3a

1. **Mark the one box that describes how much, during the past week, pain has interfered with:**

|  |  |
| --- | --- |
|  | 0= does NOT interfere 10= completely interferes |
| General activity | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Mood | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Walking activity | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Normal activity (outside the home or with housework) | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Relations with other people | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Sleep | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Enjoyment of life | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |

1. **Listed below are statements describing different thoughts and feelings that may be associated with pain. Please read each statement and circle a number 0,1,2,3, or 4 which indicates how much the statement applies to you when you are experiencing pain.**

PCS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| When I am in pain… | Not at all | To a slight degree | To a moderate degree | To a great degree | All the time |
| I worry all the time about whether the pain will end. | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I feel I can’t go on | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| It’s terrible and I think it’s never going to get any better | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| It’s awful and I feel it overwhelms me | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I feel I can’t stand it anymore | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I become afraid that the pain will get worse | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I keep thinking of other painful events | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I anxiously want the pain to go away | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I can’t seem to keep it out of my mind | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I keep thinking about how much it hurts | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I keep thinking about how badly I want the pain to stop | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| There’s nothing I can do to reduce the intensity of the pain | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I wonder whether something serious may happen | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |

1. ***If* you had BOWEL symptoms, how would you describe your BOWEL symptoms now?**

[ ] Much better

[ ] Better

[ ] About the same

[ ] Worse

[ ] Much worse

[ ] I did not have any bowel symptoms.

1. **On a scale from 0% (not improved at all) to 100% (completely better), how would you rate the change in your bowel symptoms? Click or tap here to enter text. %**
2. ***If* you had URINARY symptoms, how would you describe your URINARY symptoms now?**

[ ] Much better

[ ] Better

[ ] About the same

[ ] Worse

[ ] Much worse

[ ] I did not have any urinary symptoms.

1. **On a scale from 0% (not improved at all) to 100% (completely better), how would you rate the change in your URINARY symptoms?** Click or tap here to enter text. **%**
2. **Have you been sexually active since your last visit?**

[ ] No, ***SKIP TO QUESTION 17.*** [ ] Yes, please proceed to answering question 16

1. **Please complete the sexual questionnaire designed to capture the impact of your chronic pain on your experience of sex and sexuality.**

PROMIS Sexual Function Profile v1.0-Female

|  |
| --- |
| Interest in Sexual activity in the PAST 30 DAYS |
| 1. How interested have you been in sexual activity? | Not at all [ ] 1 | A little bit [ ] 2 | Somewhat [ ] 3 | Quite a bit [ ] 4 | Very [ ] 5 |  |
| 2. How often have you felt like you wanted to have sex? | Never[ ] 1 | Rarely[ ] 2 | Sometimes[ ] 3 | Often[ ] 4 | Always[ ] 5 |  |
| Lubrication over the PAST 4 WEEKS…  |
| 3. How often did you become lubricated ‘wet’ during sexual activity or intercourse? | No sexual activity[ ] 0 | Almost always or always[ ] 5 | Most times (more than half the time)[ ] 4 | Sometimes (about half the time)[ ] 3 | A few times (less than half of the time)[ ] 2 | Almost never or ever[ ] 1 |
| In the past 30 days… |
| 4. How difficult has it been for your vagina to be lubricated or ‘wet’ when you wanted it to? | Not at all [ ] 1 | A little bit [ ] 2 | Somewhat [ ] 3 | Quite a bit[ ] 4 | Very [ ] 5 |  |
| Vaginal Discomfort in the PAST 30 DAYS…  |
| 5. How would you describe the comfort of your vagina during sexual activity? | Have not had any sexual activity in the past 30 days[ ] 0 | Never[ ] 1 | Rarely[ ] 2 | Sometimes[ ] 3 | Often[ ] 4 | Always[ ] 5 |
| 6. How often have you had difficulty with sexual activity because of discomfort or pain in your vagina? | Have not had any sexual activity in the past 30 days[ ] 0 | Never[ ] 1 | Rarely[ ] 2 | Sometimes[ ] 3 | Often[ ] 4 | Always[x] 5 |
| 7. How often have you stopped sexual activity because of discomfort or pain in your vagina? | Have not had any sexual activity in the past 30 days[ ] 0 | Never[ ] 1 | Rarely[ ] 2 | Sometimes[ ] 3 | Often[ ] 4 | Always[ ] 5 |
| Orgasm in the PAST 30 DAYS... |
| 8. How would you rate your ability to have a satisfying orgasm/climax? | Have not tried to have an orgasm/climax in the past 30 days[ ] 0 | Excellent[ ] 5 | Very good[ ] 4 | Good[ ] 3 | Fair[ ] 2 | Poor[ ] 1 |
| Satisfaction in the PAST 30 DAYS… |
| 9. When you have had sexual activity how much have you enjoyed it? | Have not had any sexual activity in the past 30 days[ ] 0 | Not at all [ ] 1 | A little bit [ ] 2 | Somewhat [ ] 3 | Quite a bit[ ] 4 | Very [ ] 5 |
| 10. When you have had sexual activity, how satisfying has it been? | Have not had any sexual activity in the past 30 days□0 | Not at all □1 | A little bit □2 | Somewhat □3 | Quite a bit □4 | Very □5 |

1. **Since you were last seen by this pain management service, have you seen any other healthcare professionals for pain management?**

[ ] No [ ] Yes, describe:Click or tap here to enter text.

1. **Since you were last seen, have you done any other treatments that were NOT originally prescribed by your pain clinician? *(Check all that apply)***

[ ] Acupuncture [ ] Massage [ ] Nutrition/Diet [ ] Physical Therapy

[ ] Biofeedback [ ] Cognitive Behavioral Therapy

[ ] Trigger Point Injections [ ] TENS Unit [ ] Botox Injections [ ] Nerve Blocks

[ ] Epidural [ ] Sex Therapy [ ] Joint Injections [ ] Neurostimulation

[ ] Mental Health [ ] Bladder instillations

[ ] Aqua Therapy [ ] Radio Frequency Ablation

[ ] Percutaneous Tibial Nerve Stimulation

[ ] Hormonal treatment-- if yes, what type of hormonal treatment?

 (***Check all that apply)***

[ ] Pills [ ] Patch [ ] Ring [ ]  Injections [ ] Estrogen [ ] Progesterone

[ ] Other treatments:Click or tap here to enter text.

1. **Please respond to each question or statement about your GENERAL HEALTH by marking 1 box per row.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| In general, would you say your health is? | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1 |
| In general, would you say your quality of life is? | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1 |
| In general, how would you rate your physical health? | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1 |
| In general, how would you rate your mental health, including mood and your ability to think? | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1 |
| In general, how would you rate your satisfaction with your social activities and relationships? | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1 |
| In general, please rate how well you carry out your usual social activities and roles (this includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.) | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1PROMIS Global Health v.1.1 |
| To what extend are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair | Completely□5 | Mostly□4 | Moderately□3 | A little□2 | Not at all□1 |
|  |  |  |  |  |  |
| *In the past 7 days…* |  |  |  |  |  |
| How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable? | Never□1 | Rarely□2 | Sometimes□3 | Often□4 | Always□5 |
| How would you rate your fatigue on average? | None□1 | Mild□2 | Moderate□3 | Severe4□ | Very severe□5 |
| How would you rate your pain on average? | □ □□ □ □ □ □ □ □ □ □0-no pain 1 2 3 4 5 6 7 8 9 10- worst pain |

1. **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 wrong or right answers, do not spend too much time on any statement.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DASS-21 | Not at all | Some of the time | A good part of the time | Most of the time |
| I found it hard to wind down | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I was aware of dryness of my mouth | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I couldn’t seem to experience any positive feeling at all | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion) | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I found it difficult to work up the initiative to do things | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I tended to overreact to situations | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I experienced trembling (e.g. in the hands) | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt that I was using a lot of nervous energy | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I was worried about situations in which I might panic and make a fool of myself | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt that I had nothing to look forward to | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I found myself getting agitated | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I found it difficult to relax | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt downhearted and blue | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I was intolerant of anything that kept me from getting on with what I was doing | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt I was close to panic | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I was unable to become enthusiastic about anything | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt I wasn’t worth much as a person | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt that I was rather touchy | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I was aware of the action of my heart in the absence of physical exertion (e.g. a sense of heart rate increase, heart missing a beat) | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt scared without good reason | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM. THIS INFORMATION WILL HELP YOUR CLINICIAN TAKE BETTER CARE OF YOU.**

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