

The Bristol Endometriosis Clinic

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Patient label

Centre: **Bristol**
Date of clinic attendance:
Referral: Self / GP / Consultant / website / other
Private patient: YES / NO

BSGE Pelvic Pain Questionnaire (New patient)

This questionnaire has been designed to help us understand your problems and to find the most appropriate treatments. It may also help you to formulate your thoughts on your symptoms and the way in which they can affect your quality of life. It is important that you answer as many of the questions as you are able. If you find any of them awkward to answer, please leave them blank and we may discuss them at your consultation should you wish.

Please be assured that the information you provide will be kept confidential. This data will be anonymised in accordance with Data Protection legislation and entered onto a central database together with the results of clinical examination and any tests that you may have. The findings and results of any surgical intervention that you may have will be recorded and assessed, as will your responses from follow up questionnaires.

If you do not understand any of the questions, particularly about previous treatment, please leave these blank and raise the questions when you are seen in the clinic.

Please sign below to confirm that you are happy for the information that you provide to be included on the database. We will be collecting information about you throughout your treatment.

Signature

NAME (Print)

Date

GENERAL QUESTIONS ABOUT YOUR PAIN

1 Over the course of your **current normal menstrual cycle**, which of the following symptoms do you experience? Please tick yes or no to show whether you experience symptom during a normal cycle, and then if you have experienced the symptom, circle a score from 1 to 10 to indicate how slight or severe it usually is.

(Note: N/A denotes 'no periods')

| | | | | | | | | | | |
|--|-------------|---|---|---|---|------------------------------|-----------------------------|------------------------------|----|--|
| Pre-menstrual pain (pain before periods) | Experienced | | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | N/A <input type="checkbox"/> | | |
| Experienced slightly | | | | | | Experienced severely | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

| | | | | | | | | | | |
|--|-------------|---|---|---|---|------------------------------|-----------------------------|------------------------------|----|--|
| Menstrual pain (pain during periods) | Experienced | | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | N/A <input type="checkbox"/> | | |
| Experienced slightly | | | | | | Experienced severely | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

| | | | | | | | | | | |
|--|-------------|---|---|---|---|------------------------------|-----------------------------|---|----|--|
| Non-cyclical pelvic pain (pain throughout the month) | Experienced | | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | | | |
| Experienced slightly | | | | | | Experienced severely | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

| | | | | | | | | | | |
|---------------------------------------|-------------|---|---|---|---|------------------------------|-----------------------------|------------------------------|----|--|
| Pain during sexual intercourse | Experienced | | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | N/A <input type="checkbox"/> | | |
| Experienced slightly | | | | | | Experienced severely | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

| | | | | | | | | | | |
|--|-------------|---|---|---|---|------------------------------|-----------------------------|------------------------------|----|--|
| Pain opening bowels during period | Experienced | | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | N/A <input type="checkbox"/> | | |
| Experienced slightly | | | | | | Experienced severely | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

| | | | | | | | | | | |
|---|-------------|---|---|---|---|------------------------------|-----------------------------|------------------------------|----|--|
| Pain opening bowels at other times | Experienced | | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | N/A <input type="checkbox"/> | | |
| Experienced slightly | | | | | | Experienced severely | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

| | | | | | | | | | |
|------------------------|-------------|---|----------------------|---|---|------------------------------|-----------------------------|------------------------------|----|
| Lower back pain | Experienced | | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| Experienced slightly | | | Experienced severely | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

| | | | | | | | | | |
|---|-------------|---|----------------------|---|---|------------------------------|-----------------------------|---|----|
| Bladder pain or pain passing urine | Experienced | | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | | |
| Experienced slightly | | | Experienced severely | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

| | | | | | | | | | |
|--|---|---|----------------------|---|---|------------------------------|-----------------------------|---|----|
| Do you have difficulty emptying your bladder? | | | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | | |
| Experienced slightly | | | Experienced severely | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Information about bowel function

(Note: N/A denotes stoma)

2 Do you have frequent bowel movements?

Never⁰ a little of the time¹ some of the time² most of the time³ all of the time⁴ N/A⁵

Do you have urgent bowel movements?

Never⁰ a little of the time¹ some of the time² most of the time³ all of the time⁴ N/A⁵

Do you have a sensation of incomplete emptying of the bowel?

Never⁰ a little of the time¹ some of the time² most of the time³ all of the time⁴ N/A⁵

Do you have constipation?

Never⁰ a little of the time¹ some of the time² most of the time³ all of the time⁴ N/A⁵

Have you been troubled by blood in the stool around the same time as your period?

Never⁰ a little of the time¹ some of the time² most of the time³ all of the time⁴ N/A⁵

Fertility

3 Are you currently trying to get pregnant?

No

Yes, been trying for more than 18 months

Previous treatment for endometriosis

4 Are you currently taking any of the following treatments? Please tick to indicate your use.

- **Oral contraceptive Pill** YES NO
- **Mirena IUS (hormone containing coil)** YES NO
- **GnRH Analogues,
eg Goserelin, Buserelin, Lupron, Naferelin** YES NO
- **GnRH Analogues + oestrogens (HRT)** YES NO
- **Progestogens
eg Primolut, Duphaston, Provera** YES NO
- **Analgesics/painkillers**
Paracetamol YES NO
- NSAID anti-inflammatories ,
eg Ibuprofen, Diclofenac YES NO
- Opiates, eg Tramadol, DF118 YES NO

Previous surgery for endometriosis

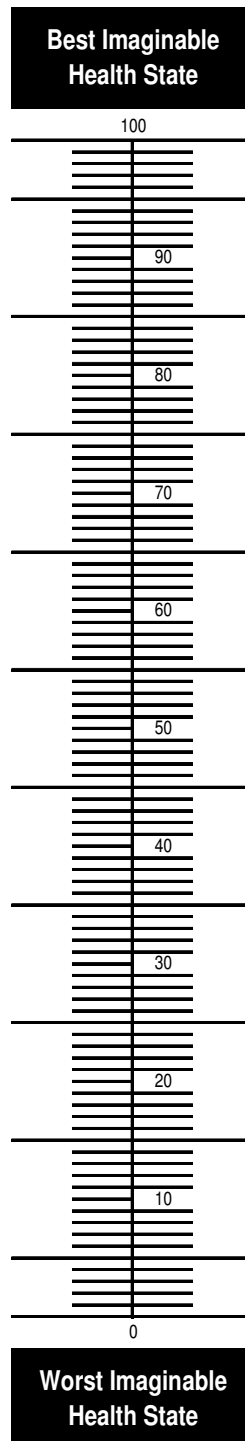
- 5 Have you had your endometriosis surgically treated? Yes No
- Have you had an ovary removed? Yes No Don't know
- Have you had both ovaries removed? Yes No Don't know
- Have you had a hysterectomy? Yes No Don't know

Questions about your health in general

6 The following questions refer to how you feel about your health in general **TODAY**. They form part of a standard set of questions relating to quality of life and therefore some may not seem particularly relevant to you. However, please try to answer ALL questions.

Please score how good or bad your health is **TODAY**. The best health state you can imagine is marked 100 and the worst health state you can imagine is marked 0.

(Please place a line on the scale between 1 and 100 according to how you feel)



7 Please indicate which statements best describe your health state **TODAY**

Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

Pain/Discomfort

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

Anxiety/Depression

- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed

Mobility

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

Self-Care

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

Thank you very much for completing this questionnaire. We would like to reassure you again that all the answers will be treated in the strictest confidence.