Women's Urology and Pelvic Health Center | Patient History Questionnaire

Today's Date: _____

At the Women's Urology and Pelvic Health Center, our goal is to bring you state-of-the-art care. Your answers help us better understand you and your past experiences. Your responses also help us in our research to better understand the conditions we treat. Please take your time when completing this packet and supply all information as fully as possible. If you have questions or concerns, please talk to your provider.

Name:	Date of birth:
Preferred name:	Age:

Primary phone: ☐ Home ☐Cell ☐ Work	Secondary phone: ☐ Home ☐Cell ☐ Work

OK to leave detailed message?	☐ Yes	☐ No
Would you like to receive text message appointment reminders?	☐ Yes	☐ No
Primary hospital: ☐ Beaumont ☐ Other _____		

What is the main reason for your visit today?

Marital Status:	☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced
Who lives with you? Check all that apply	☐ Alone ☐Spouse ☐ Children ☐ Friend/Roommate ☐ Other
Education:	☐ Less than 12 years ☐ Some college ☐ Postgraduate degree ☐ High school graduate ☐ College Degree
Employment Status:	☐ Unemployed ☐ Part-time ☐Full-time ☐ Retired ☐ Disabled
Occupation:	
Tobacco use:	☐ Never used ☐ Current smoker _____ packs per day for _____ years ☐ Former smoker _____ per day for _____ years Quit date: _____

Medical History		
☐ Back Injury	☐ High blood pressure	☐ Fibromyalgia
☐ Shingles	☐ Heart problems	☐ Multiple sclerosis
☐ Endometriosis	☐ Diabetes ☐Type 1 ☐Type 2	☐ Anxiety
☐ Tuberculosis	☐ Asthma	☐ Depression
☐ Hepatitis	☐ Thyroid disease	☐ Bipolar disorder
☐ Chronic fatigue syndrome	☐ Epstein Barr	☐ Post-traumatic stress disorder (PTSD)
☐ Seizures	☐ Lupus	☐ Eating disorder
☐ Migraines	☐ Parkinson's Disease	☐ Personality disorder
☐ Cancer Type:	☐ Sleep disorder	☐ Other psychological problem Type:
Other:		

Surgical History			
Surgery	Date	Surgery	Date

Family Medical History ☐ Check here if family medical history is unknown *Check illness which has occurred in any blood relative and write relationship to you*			
☐	Bladder/kidney cancer	☐	Autoimmune disease
☐	Uterine/ovarian cancer	☐	Crohn's/ulcerative colitis
☐	Colorectal cancer	☐	Colon polyps
☐	Breast cancer	☐	Multiple sclerosis
☐	Chronic pelvic pain	☐	Fibromyalgia
☐	Bladder prolapse	☐	Kidney stones
☐	Interstitial cystitis	☐	Other:

Medications			
Allergies: ☐ No ☐ Yes, please specify: _____			
Medication Name (include prescription, over the counter, supplements, and topicals)	Strength or dose	Frequency	Month/year started

Urologic History					
Have you seen a urologist before? ☐ Yes ☐ No If yes, why? _____ Urologist's name: _____					
How often do you urinate **during the day**?	☐ < 30 min	☐ 30-60 min	☐ 1-2 hrs	☐ 3-4 hrs	☐ > 4 hrs
How many times do you urinate **at night**?	☐ 0	☐ 1-2	☐ 3-4	☐5-6	☐6+
On average, how much do you drink each day (oz)? Water: Soda/pop: Coffee/tea: Alcohol: Other:					
Do you have a strong urge to empty your bladder?	☐ Yes ☐ No				
If so, are you able to get to the bathroom in time?	☐ Yes ☐ No				
Do you leak with coughing, sneezing, or laughing?	☐ Yes ☐ No				

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Do you wear protective pads due to urine leakage?	☐ Yes (☐ thick pad ☐ thin pad)☐ No
Do you have frequent bladder or urinary tract infections? (3 or more a year)	☐ Yes ☐ No
Have you had kidney stones?	☐ Yes ☐ No
Do you ever wet the bed while asleep?	☐ Yes ☐ No
Have you ever been diagnosed with *interstitial cystitis*? If yes: Year: _____ By whom: _____ Did you have a *cystoscopy with hydrodistention*? Have you been told you have *Hunner's ulcers*?	☐ Yes ☐ No ☐ Not sure ☐ Yes ☐ No ☐ Not sure ☐ Yes ☐ No ☐ Not sure

Gynecologic History				
Birth Control Method:	☐ Not sexually active	☐ Menopause	☐ Hysterectomy	☐ Female partner
	☐ Tubal ligation	☐ Vasectomy	☐ Condoms	☐ Pill/patch/ring
	☐ Depo shot	☐ Mirena IUD	☐ Paragard IUD	☐ Implant
	☐ Withdrawal	☐ Spermicide	☐ Diaphragm	☐ None
Current gynecologist:				
Date of Last Pap smear:	_____ History of abnormal pap smear? ☐ Yes ☐ No			
Infection history:	☐ Herpes	☐ HPV/warts	☐ Chlamydia	☐ HIV ☐ Yeast
	☐ Gonorrhea	☐ Syphilis	☐ Trichomonas	☐ Bacterial Vaginosis

Menstrual History *(skip this section if you do not currently have menstrual periods)*	
First day of **last** menstrual period:	Age of **first** period:
How many days does your period last?	How often does your period occur?
Pain with periods? ☐ No ☐ Before ☐ During	
Bleeding is: ☐ Heavy ☐ Moderate ☐ Light	Bleeding between periods? ☐ Yes ☐ No

Obstetric History			
Number of pregnancies:			Number of births:
Year	Birth weight	Vaginal or C-section?	Complications (including stitches, tears, infection, vacuum/ forceps, unusual bleeding, gestational diabetes, preeclampsia, etc.)

Menopause History *(skip this section if not menopausal)*	
Menopause age: _____	Concerns about menopausal symptoms today? ☐ No ☐ Yes If yes, please explain:
How did you go through menopause:	☐ Naturally ☐ Medication induced ☐ Surgically—check all that apply ☐ uterus only removed ☐ uterus and one ovary removed ☐ uterus and both ovaries removed ☐ unsure ☐ abdominal ☐ laparoscopic ☐ vaginal
Hormone replacement therapy?	☐ Current ☐ Past (years: _____) ☐ Never Type: _____

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Sexual Health History	
Are you sexually active? ☐ Yes ☐ No	Age of first sexual activity:
Sexually active with (check all that apply):	☐ Men ☐ Women ☐_____
Are you satisfied with your sexual activity status?	☐ Yes ☐ No
Do you have pain with sexual activity?	☐ Yes ☐ No
Any recent difficulty with orgasm or decreased libido?	☐ Yes ☐ No ☐ n/a
Would you like to discuss your sexual health at your visit?	☐ Yes ☐ No

If you have specific concerns regarding your sexual health, please fill out the questionnaire on page 15.

Bowel History	
Do you frequently have constipation?	☐ Yes ☐ No
Do you leak stool or bowel contents?	☐ Yes ☐ No
Have you been diagnosed with irritable bowel syndrome?	☐ Yes ☐ No
Do you experience frequent diarrhea?	☐ Yes ☐ No
Do you experience any rectal bleeding?	☐ Yes ☐ No
Have you seen blood in/on your stool?	☐ Yes ☐ No
When was your last colonoscopy?	Year: _____ ☐ n/a

Psychological History	
Have you ever seen a psychologist, counselor, or psychiatrist?	☐ Yes, currently ☐ Yes, in the past ☐ Never
History of psychiatric hospitalization(s)? ☐ Yes ☐ No If yes, please note year(s):	

The following questions ask about abuse. If you have experienced abuse of any kind, please know that you are not alone. We know that abuse is widespread for women and girls, as well as men and boys. We appreciate your sharing this sensitive information with us. If any experiences like these ever come up, please know that **this is a safe place to talk about it and get help.**

Abuse History/Intimate Partner Violence Screening			
Have you ever been abused?	☐ Yes ☐ No		
If yes, what type(s) of abuse have you experienced, and at what ages? *If no, please skip to the next section.*			
Please check all that apply:			
Physical:	☐ During childhood	☐ As a teenager	☐ As an adult
Verbal :	☐ During childhood	☐ As a teenager	☐ As an adult
Emotional:	☐ During childhood	☐ As a teenager	☐ As an adult
Sexual :	☐ During childhood	☐ As a teenager	☐ As an adult
Intimate partner:	☐ During childhood	☐ As a teenager	☐ As an adult
Would you like a referral for assistance or counseling?		☐ Not at this time	☐ Yes

Cannabis Use			
Do you use cannabis (marijuana)?	☐ Yes	☐ No	☐ Choose not to respond
If yes, what forms of cannabis do you use? *Check all that apply*	☐ Smoking ☐ Cream/Ointment	☐ Eating/Edibles	☐ CBD Oil ☐ Other: _____
If yes, how frequently do you use cannabis?	☐ Never ☐2-3 times per week	☐Monthly or less	☐2-4 times a month ☐ 4 or more times a week

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Alcohol Use	
How often did you have a drink containing alcohol in the past year? Consider a drink a bottle of beer, a glass of wine, a wine cooler, one cocktail, or a shot of hard liquor (like scotch, gin, or vodka)	☐ Never ☐Monthly or less ☐2-4 times a month ☐2-3 times per week ☐ 4 or more times a week
How many drinks did you have on a typical day when you were drinking in the past year?	☐ 0 drinks ☐1-2 drinks ☐3-4 drinks ☐5-6 drinks ☐ 7-9 drinks ☐ 10+ drinks
How often did you have 4 or more drinks on one occasion in the past year?	☐ Never ☐Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Pain History					
Describe your current pain:					
Please rate the duration of your pain, and pain level (0-10) at each pain location below (0 = no pain 10 = severe pain)					
Pelvic Pain level: */10*	☐ <6 mos	☐ 6-12 mos	☐ 1-2 yrs	☐ 2-5 yrs	☐ 5+ yrs
Bladder Pain level: */10*	☐ <6 mos	☐ 6-12 mos	☐ 1-2 yrs	☐ 2-5 yrs	☐ 5+ yrs
Rectal Pain level: */10*	☐ <6 mos	☐ 6-12 mos	☐ 1-2 yrs	☐ 2-5 yrs	☐ 5+ yrs
Abdominal Pain level: */10*	☐ <6 mos	☐ 6-12 mos	☐ 1-2 yrs	☐ 2-5 yrs	☐ 5+ yrs
Hip Pain level: */10*	☐ <6 mos	☐ 6-12 mos	☐ 1-2 yrs	☐ 2-5 yrs	☐ 5+ yrs
Vaginal/Vulvar Pain level: */10*	☐ <6 mos	☐ 6-12 mos	☐ 1-2 yrs	☐ 2-5 yrs	☐ 5+ yrs
What triggered this pain?					
Do you engage in any of the following activities?	☐ Yoga ☐ Biking	☐ Horseback riding ☐ Weight lifting/strength training	☐ Spinning	☐ Pilates	
How do you currently manage your pain?	☐ Medications ☐ Injections ☐ TENS unit ☐ Acupuncture/integrative medicine	☐ Ice ☐ Implanted device ☐ Relaxation techniques	☐ Heat	☐ Rest/restricting activities ☐ Physical therapy ☐ Chiropractor ☐ Other: _____	

Pelvic Pain *0 = no pain 10 = severe pain*											
What is your level of pain with vaginal insertion? *(e.g., tampons, intercourse, dilator/vibrator)*	0	1	2	3	4	5	6	7	8	9	10
What is your level of **burning-type** vaginal pain **during** insertion**?**	0	1	2	3	4	5	6	7	8	9	10
What is your level of **burning-type** vaginal pain **after** insertion?	0	1	2	3	4	5	6	7	8	9	10
What is your level of **deep pain** during insertion?	0	1	2	3	4	5	6	7	8	9	10
What is your level of pain at the **vaginal opening** during insertion?	0	1	2	3	4	5	6	7	8	9	10
Overall, what would be an acceptable level of pain for you?	0	1	2	3	4	5	6	7	8	9	10

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Three most significant stressors in your life right now:
1.
2.
3.

Treatment Goals: List your primary treatment goal(s) that you hope to accomplish today:
1.
2.
3.

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OAB-Q (Bother)						
During the past 4 weeks, how bothered were you by…	Not at all	A little bit	Some-what	Quite a bit	A great deal	A very great deal
1. An uncomfortable urge to urinate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
2. A sudden urge to urinate with little or no warning?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
3. Accidental loss of small amounts of urine?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
4. Nighttime urination?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
5. Waking up at night because you had to urinate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
6. Urine loss associated with a strong desire to urinate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

OAB-Q (Health Related Quality of Life)						
During the past 4 weeks, how often have your bladder symptoms…	Not at all	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
1. Caused you to plan “escape routes” to restrooms in public places?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
2. Made you feel like there is something wrong with you?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
3. Interfered with your ability to get a good night’s rest?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
4. Made you frustrated or annoyed about the amount of time you spend in the restroom?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
5. Made you avoid activities away from restrooms (i.e. walks, running, hiking)?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
6. Awakened you during sleep?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
7. Caused you to decrease your physical activities (exercising, sports, etc.)?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
8. Caused you to have problems with your partner or spouse?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
9. Made you uncomfortable while traveling with others because of needing to stop for a restroom?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
10. Affected your relationships with family and friends?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
11. Interfered with getting the amount of sleep you needed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
12. Caused you embarrassment?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
13. Caused you to locate the closest restroom as soon as you arrive at a place you have never been?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

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Pelvic Floor Distress Inventory

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and if you do how much they bother you. Answer each question by putting an X in the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the last 3 months.

		If yes, how much does it bother you?			
		Not at all	Some-what	Mode-rately	Quite a bit
1. Do you usually experience pressure in the lower abdomen?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
2. Do you usually experience heaviness or dullness in the lower abdomen?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
4. Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
5. Do you usually experience a feeling of incomplete bladder emptying?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
6. Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
7. Do you feel you need to strain too hard to have a bowel movement?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
9. Do you usually lose stool beyond your control if your stool is well formed?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
11. Do you usually lose gas from the rectum beyond your control?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
12. Do you usually have pain when you pass your stool?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
14. Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
15. Do you usually experience frequent urination?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
16. Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
17. Do you usually experience urine leakage related to laughing, coughing, or sneezing?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
18. Do you usually experience small amounts of urine leakage (that is, drops)?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
19. Do you usually experience difficulty emptying your bladder?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
20. Do you usually experience pain or discomfort in the lower abdomen or genital region?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4

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GAD-7 (Anxiety Screening Tool)				
Over the past 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it is hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3

PHQ-8 (Depression Screening Tool)				
Over the past 2 weeks, how often have you been bothered by any of the following:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much?	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy?	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating?	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down?	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television?	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	☐ 0	☐ 1	☐ 2	☐ 3

If the reason for your visit is **not related to pain**,
you **do not** need to complete pages 10-14 of this questionnaire.

If you are experiencing pain, please complete the next 4 pages.

If you have concerns regarding your sexual health, please complete pages 15-17. Thank you.

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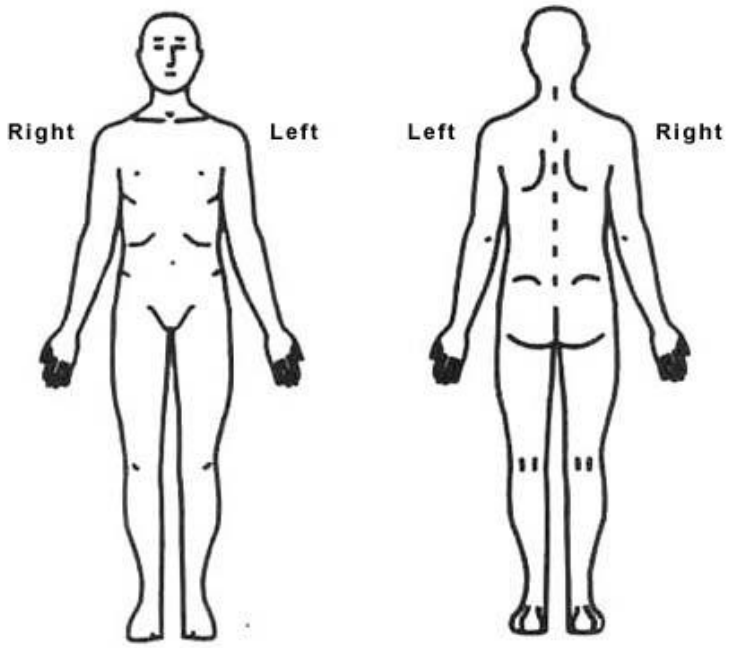
Brief Pain Inventory (BPI)

1. Throughout our lives, most of us have pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-days kinds of pain today?
   ☐ Yes ☐ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on **average**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have **right now**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

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7. What treatments or medications are you receiving for your pain?

_____
_____
_____

8. In the last 24 hours, how much **relief** have pain treatment or medication provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9. Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your

a. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

b. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

c. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

d. Normal work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

e. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

f. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

g. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

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PCS (Pain Distress Measure)

Everyone experiences painful situations at some point in their lives. Such experiences may include pelvic pain, headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures, or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain.

Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
1. I worry all the time about whether the pain will end	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. I feel I can't go on	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. It's terrible and I think it's never going to get any better	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. It's awful and I feel that it overwhelms me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. I feel I can't stand it anymore	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. I become afraid that the pain will get worse	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. I keep thinking of other painful events	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. I anxiously want the pain to go away	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. I can't seem to keep it out of my mind	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. I keep thinking about how much it hurts	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11. I keep thinking about how badly I want the pain to stop	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12. There's nothing I can do to reduce the intensity of the pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
13. I wonder whether something serious may happen	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

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ESSI (Social Support Screening Tool)					
Please read the following questions and check the response that most closely describes your current situation:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. Is there someone available to you whom you can count on to listen to you when you need to talk?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. Is there someone available to give you good advice about a problem?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. Is there someone available to you who shows you love and affection?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. Is there someone available to help you with daily chores?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6.Do you have as much contact as you would like with someone you feel close to, someone in whom you can trust and confide?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. Are you currently married or living with a partner? ☐ Yes ☐ No					

PC-PTSD-5 (Post Traumatic Stress Disorder [PTSD] Screening Tool)		
Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: *a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone killed or seriously injured, or having a loved one die through homicide or suicide.* Have you ever experienced this kind of event? ☐ Yes ☐ No If *no*, please stop here and go to the next page. If *yes*, please answer the questions below.		
In the past month, have you …	**Yes**	**No**
1. had any nightmares about the event(s), or thought about the event(s) when you did not want to?		
2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?		
3. been constantly on guard, watchful, or easily startled?		
4. felt numb or detached from people, activities, or your surroundings?		
5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?		

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Adverse Childhood Experience (ACE) Questionnaire		
Many people have experienced stressful events as children. *These events may have an impact on long-term physical and mental health.*		
While you were growing up, during your first 18 years of life:	**Yes**	**No**
1. Did a parent or other adult in the household **often** … Swear at you, insult you, put you down, or humiliate you? **or** Act in a way that made you afraid that you might be physically hurt?		
2. Did a parent or other adult in the household **often** … Push, grab, slap, or throw something at you? or **Ever** hit you so hard that you had marks or where injured?		
3. Did an adult or person at least 5 years older than you **ever** … Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you?		
4. Did you **often** feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?		
5. Did you **often** feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
6. Were you parents **ever** separated or divorced?		
7. Was your mother or stepmother: **Often** pushed, grabbed, slapped, or had something thrown at her? or **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? or **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?		
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
9. Was a household member depressed or mentally ill or did a household member attempt suicide?		
10. Did a household member go to prison?		

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Female Sexual Function Index (FSFI)

Instructions: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions, the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation, and vaginal intercourse.

Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, masturbation, or sexual fantasy.

CHECK ONLY ONE BOX PER QUESTION.

Sexual desire or interest is a feeling that includes wanted to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?
   - ☐ Very high
   - ☐ High
   - ☐ Moderate
   - ☐ Low
   - ☐ Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?
   - ☐ No sexual activity
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?
   - ☐ No sexual activity
   - ☐ Very high
   - ☐ High
   - ☐ Moderate
   - ☐ Low
   - ☐ Very low or none at all

5. Over the past 4 weeks, how **confident** were you about being sexually aroused during sexual activity or intercourse?
   - ☐ No sexual activity
   - ☐ Very high confidence
   - ☐ High confidence
   - ☐ Moderate confidence
   - ☐ Low confidence
   - ☐ Very low or no confidence

6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?
   - ☐ No sexual activity
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricated ("wet") during sexual activity or intercourse?
    - ☐ No sexual activity
    - ☐ Almost always or always
    - ☐ Most times (more than half the time)
    - ☐ Sometimes (about half the time)
    - ☐ A few times (less than half the time)
    - ☐ Almost never or never

8. Over the past 4 weeks, how **difficult** was it to become lubricated ("wet") during sexual activity or intercourse?
    - ☐ No sexual activity
    - ☐ Extremely difficult or impossible
    - ☐ Very difficult
    - ☐ Difficult
    - ☐ Slightly difficult
    - ☐ Not difficult

9. Over the past 4 weeks, how often did you **maintain** your lubrication ("wetness") until completion of sexual activity or intercourse?
    - ☐ No sexual activity
    - ☐ Almost always or always
    - ☐ Most times (more than half the time)
    - ☐ Sometimes (about half the time)
    - ☐ A few times (less than half the time)
    - ☐ Almost never or never

10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?
    - ☐ No sexual activity
    - ☐ Extremely difficult or impossible
    - ☐ Very difficult
    - ☐ Difficult
    - ☐ Slightly difficult
    - ☐ Not difficult

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax?)
    - ☐ No sexual activity
    - ☐ Almost always or always
    - ☐ Most times (more than half the time)
    - ☐ Sometimes (about half the time)
    - ☐ A few times (less than half the time)
    - ☐ Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how difficult was it for you to reach orgasm (climax)?
    - ☐ No sexual activity
    - ☐ Extremely difficult or impossible
    - ☐ Very difficult
    - ☐ Difficult
    - ☐ Slightly difficult
    - ☐ Not difficult

13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?
    - ☐ No sexual activity
    - ☐ Very satisfied
    - ☐ Moderately satisfied
    - ☐ About equally satisfied and dissatisfied
    - ☐ Moderately dissatisfied
    - ☐ Very dissatisfied

14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?
    - ☐ No sexual activity
    - ☐ Very satisfied
    - ☐ Moderately satisfied
    - ☐ About equally satisfied and dissatisfied
    - ☐ Moderately dissatisfied
    - ☐ Very dissatisfied

15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?
    - ☐ No sexual activity
    - ☐ Very satisfied
    - ☐ Moderately satisfied
    - ☐ About equally satisfied and dissatisfied
    - ☐ Moderately dissatisfied
    - ☐ Very dissatisfied

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16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?
    - ☐ Very satisfied
    - ☐ Moderately satisfied
    - ☐ About equally satisfied and dissatisfied
    - ☐ Moderately dissatisfied
    - ☐ Very dissatisfied

17. Over the past 4 weeks, how **often** did you experience discomfort or pain <u>during</u> vaginal penetration?
    - ☐ Did not attempt intercourse
    - ☐ Almost always or always
    - ☐ Most times (more than half the time)
    - ☐ Sometimes (about half the time)
    - ☐ A few times (less than half the time)
    - ☐ Almost never or never

18. Over the past 4 weeks, how **often** did you experience discomfort or pain <u>following</u> vaginal penetration?
    - ☐ Did not attempt intercourse
    - ☐ Almost always or always
    - ☐ Most times (more than half the time)
    - ☐ Sometimes (about half the time)
    - ☐ A few times (less than half the time)
    - ☐ Almost never or never

19. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?
    - ☐ Did not attempt intercourse
    - ☐ Very high
    - ☐ High
    - ☐ Moderate
    - ☐ Low
    - ☐ Very low or none at all

Thank you for completing this questionnaire

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