Saint Louis University
Center for Endometriosis Questionnaire
PRE-OPERATIVE

Patient Name: _____ Date: _____

Date of Birth: _____/_____/_____ Email:_____

DEMOGRAPHICS

1) State/Province where you reside: _____ **2) Age**: _____

4) Ethnicity (check 1 of 2):

☐ Hispanic or Latino ☐ Not Hispanic or Latino

5) Race (check 1 of 7):

☐ White
☐ Black or African American
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ More than one race
☐ Other: _____

6) Who is your primary care physician?_____

Phone Number: _____
Mailing Address: _____
Fax: _____

7) Who is your primary gynecologist?_____

Phone Number: _____
Mailing Address: _____
Fax: _____

8) Who referred you to the Center for Endometriosis? _____

Phone Number: _____
Mailing Address: _____
Fax: _____

ALLERGIES: Please list medications to which you are allergic and the kinds of reactions you get.

Medication Name	Reaction	Medication Name	Reaction

MEDICATIONS: Please list names, doses, and how often you take them.

Medication Name	Dose	How often taken

Saint Louis University IRB #20900; Approved 03/21/2013; Board #1

Pharmacy Name: _____ Pharmacy Phone: _____

SYMPTOMS

1) Please indicate if you have the following symptoms AND rate their intensity on a scale from 0 to 10 (with 0 – none, 10 – worst imaginable)		**IF YES: Circle one (1 – 10, with 1 being least pain and 10 worst imaginable)**
Have you had chronic pelvic pain (meaning pelvic pain between the thighs and umbilicus not during the period) for at least 3 months?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have painful periods that affect your daily life?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have crampy, "period-like" pain, but without bleeding?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have low back pain that gets worse with your period?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have pain with bowel movements or other bowel symptoms related to your period?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have pain with urination, urinary frequency, or urgency?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have any deep pain with intercourse?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have superficial pain (on insertion) with intercourse?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have pelvic pain that lingers for several hours after intercourse?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10

2) Please rate your overall quality of life (0 – worst imaginable, 100 - perfect): _____

SCREENING QUESTIONS

3) Are you doubling over in pain, or lying down in pain, during your period? ☐YES ☐NO

4) Have you had to miss school or work due to pelvic pain? ☐YES ☐NO

5) Have you been to the Emergency Room for pelvic pain but have not been given a specific diagnosis? ☐YES ☐NO

6) Have you had to take narcotics for pelvic pain? ☐YES ☐NO

7) Have you taken hormonal suppression or birth control pills for pelvic pain or painful periods without adequate relief? ☐YES ☐NO

8) Did your mother have, or do you have a sister with, endometriosis? ☐YES ☐NO

PAST TREATMENTS:

9) Have you had previous surgery or diagnostic laparoscopy for pelvic pain or for infertility?
☐YES ☐NO

If yes, how many surgeries have you had? _____

If yes, please list as best as possible the month and year of each surgery: _____

If yes, please answer the following two questions as best you can:

a) What was the most severe stage of endometriosis found? *(please circle one)*
None I II III IV not known

b) What type of treatment did you receive? *(please circle all that apply)*
None ablation excision post-op medication not known

10) Have you **ever** been on hormonal suppression (examples include birth control pills, injections, Mirena IUD) for pain with menstrual cramps? ☐YES ☐NO

If yes, what have you tried **in the past**?

a. Cyclic (monthly bleed) Birth Control Pill ☐YES ☐NO
   - *If YES how many MONTHS total lifetime* _____
   - *If YES what are the reasons?* ☐Pain ☐Other ☐Both

b. Continuous (bleed no more than every 3 months) Birth Control Pill ☐YES ☐NO
   - *If YES how many MONTHS total lifetime* _____
   - *If YES what are the reasons?* ☐Pain ☐Other ☐Both

c. Mirena IUD ☐YES ☐NO
   - *If YES how many MONTHS total lifetime* _____
   - *If YES what are the reasons?* ☐Pain ☐Other ☐Both

d. Depo Provera ☐YES ☐NO
   - *If YES how many MONTHS total lifetime* _____
   - *If YES what are the reasons?* ☐Pain ☐Other ☐Both

e. Lupron ☐YES ☐NO
   - *If YES how many MONTHS total lifetime* _____
   - *If YES what are the reasons?* ☐Pain ☐Other ☐Both

Are you **currently** on any of the medications listed above? If so which one? _____

*If **NOT currently on*** hormonal suppression, when were you last on it (in months)?
_____/Never

OBSTETRICAL/PREGNANCY HISTORY:

1) Are you currently pregnant? ☐YES ☐NO

2) Please fill out the following table regarding your pregnancy history:

	Number	Any complications with pregnancies or deliveries?
Total pregnancies		
Total deliveries before 20 weeks		
Total full term deliveries		
Preterm (>3 weeks before due date)		
Abortions		
Miscarriages		
Ectopic Pregnancies		
Multiples (twins, triplets, etc.)		
Number of living children		

GYNECOLOGICAL HISTORY

11) At what age did you begin to have periods? _____

12) When was the first day of your last period? _____

13) When was your last pap smear? (Fill in a date or circle never). _____ /Never

14) Have you ever had an abnormal pap smear? _____

15) At what age did you begin to have pelvic pain symptoms? (Or never) _____ /Never

16) At what age did you start using hormonal suppression (birth control pills, injections, Mirena IUD) specifically to control symptoms (or never)? _____/Never

17) At what age did you first have diagnostic laparoscopy to look for endometriosis? (Or never) _____/Never

18) Are you, or have you ever been, sexually active? ☐YES ☐NO

If yes, how long have you been sexually active (in months)? _____

If yes, how long have you been sexually active *without contraception?* _____

19) Have you ever had a sexually transmitted disease (STD)? ☐YES ☐NO

If yes, what did you have and when was it diagnosed? _____

When were you last tested negative for an STD? (Month/year) _____

20) When was your last mammogram? (Or never) _____/Never

21) When was your last colonoscopy? (Or never) _____/Never

22) Are you trying to achieve pregnancy? ☐YES ☐NO

If yes, how long have you been trying to achieve pregnancy (in total months)? _____

If yes, how long have you been trying to achieve pregnancy by having sexual relations during your fertile period (in total months)? _____

MEDICAL PROBLEMS: Please Circle YES or NO

Abnormal Pap	Y	N	Anemia	Y	N	Anesthetic Complications	Y	N
Arthritis	Y	N	Asthma	Y	N	Bladder/ Kidney Infections	Y	N
Cancer	Y	N	Cataracts	Y	N	Chlamydia	Y	N
Crohn's Disease/ Ulcerative Colitis	Y	N	Congenital Heart Disease	Y	N	Congestive Heart Failure	Y	N
Depression	Y	N	DVT (blood clots)	Y	N	Emphysema/ COPD	Y	N
Epilepsy/ Seizures	Y	N	Fibromyalgia	Y	N	Gestational Diabetes	Y	N
Glaucoma	Y	N	Gonorrhea	Y	N	Heart Attack	Y	N
Heart Murmur	Y	N	Heart Problems	Y	N	Hepatitis: Viral	Y	N
Heartburn/ GERD	Y	N	Herpes	Y	N	HIV/ AIDS	Y	N
HPV	Y	N	Hypertension	Y	N	Irritable Bowel Syndrome	Y	N
Interstitial Cystitis	Y	N	Kidney Disease	Y	N	Kidney Stones	Y	N
Migraines	Y	N	Osteoporosis/ Penia	Y	N	Pulmonary Embolus	Y	N
Sickle Cell Trait	Y	N	Sickle Cell Disease	Y	N	Stroke	Y	N
Syphilis	Y	N	Thyroid Disease	Y	N	Trichomonas	Y	N
Tuberculosis	Y	N	Type 1 Diabetes	Y	N	Type 2 Diabetes	Y	N

23) Other medical problems not mentioned above: _____

SURGICAL HISTORY: Please Circle YES or NO

Appendectomy	Y	N	Ovaries and Tubes Removed	Y	N	Cervical Biopsy	Y	N
Cervical Cerclage	Y	N	Gallbladder removed	Y	N	Cervical Cone Biopsy	Y	N
C-Section	Y	N	D & C	Y	N	Heart Bypass Surgery	Y	N
Hernia Repair	Y	N	Hysteroscopy	Y	N	LEEP	Y	N
Mastectomy	Y	N	Single Ovary removed	Y	N	Ovarian Cyst removed	Y	N
Tonsillectomy	Y	N	Abdominal Hysterectomy	Y	N	Vaginal Hysterectomy	Y	N
Tubal Ligation	Y	N	Vulvar Biopsy	Y	N	Diagnostic Laparoscopy	Y	N

Other: _____

FAMILY HISTORY: Please fill in the chart below and check the appropriate boxes

Relationship	Status (Alive/Deceased)	Diabetes	Breast Cancer	Ovarian Cancer	Colon Cancer	Osteoporosis	Heart Disease	Hypertension	Elevated Lipids	Deep Vein Thrombosis	Pulmonary Embolism	Depression	Endometriosis	Interstitial Cyst	Vulvudynia	Prostate Cancer	Uterine Cancer	Stroke
Paternal Grandfather																		
Paternal Grandmother																		
Maternal Grandfather																		
Maternal Grandmother																		
Father																		
Mother																		
Brother																		
Sister																		
Child																		
Other																		

SOCIAL HISTORY: Tell me about yourself and your habits.

TOBACCO USE		ALCOHOL USE	
	I currently smoke ___ pack/day for ___ years		I currently use alcohol, and drink about ___drinks a week
	I have never smoked		I do not drink alcohol
	I used to smoke, but quit in _____		
	I have only been exposed to passive smoke (others smoke, but not me)		
	I use chewing tobacco		
STREET DRUG USE			
	Yes, I use street drugs. List kinds:		No, I do not use street drugs.

Marital Status	SINGLE	MARRIED	Separated	DIVORCED	WIDOWED

Sexual Preference	Men	Women	Both

REVIEW OF SYMPTOMS: Please circle if you have had these or circle none.

Constitutional:	Fever, chills, sweats, fatigue, malaise, anorexia, weight loss	None
Eyes:	Contacts/ glasses, cataracts, glaucoma, visual disturbance, irritation, redness, yellow in eyes, color blindness.	None
Head and Neck:	Hearing loss, ringing in ears, ear drainage, earache, nasal congestion, bloody noses, snoring, sore mouth, sore throat, hoarseness, voice changes	None
Breathing:	Cough, sputum, coughing up blood, pleurisy, pneumonia, asthma, wheezing, shortness of breath on exertion, emphysema.	None
Heart and Circulation	Chest pain, chest discomfort, shortness of breath, palpitations, irregular heartbeat, near fainting, fainting, fatigue.	None
Intestinal:	Difficulty swallowing, painful swallowing, reflux/ heartburn, nausea, vomiting, change in bowel habits, black or bloody stool.	None
Genitourinary:	Frequent urination, painful urination, waking up to urinate at night, leaking urine, difficulty starting to urinate, decreased stream, blood in urine.	None
Skin and Breast:	Rash, skin lesions, itching, dryness, skin color change, change in mole, breast lump, nipple discharge.	None
Blood:	Easy bruising, bleeding easily, swollen glands, broken blood vessels.	None
Muscles	Pain in muscles, joint pain, still joints, neck pain, back pain, muscle weakness, bone pain.	None
Nerves	Headache, dizziness, seizures, memory problems, speech problems, tingling, coordination problems, difficulty walking, tremor, weakness.	None
Psychiatric	Abusive relationship, ADHD, aggressive behavior, anorexia, anxiety, bad moods, behavior problems, bipolar, borderline personality, depression, alcoholism.	None
Glands	Diabetes, fertility problems, temperature intolerance.	None
Allergy	Rashes, hay fever, angioedema, anaphylaxis.	None