BSGE 6-24 Month Pain and Symptoms

Private or NHS patient:

□ Private

□ NHS

BSGE Pelvic Pain Questionnaire

This questionnaire has been designed to help us understand your symptoms and help find the most appropriate treatments.

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

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

The anonymised information collected on all patients will be used for research and study into the treatment of endometriosis, and may be published in medical journals or presented at medical scientific meetings to help us further our understanding of endometriosis.

If you are not clear about any of the questions, particularly about previous treatment, please leave these blank and raise the questions when you are seen in the clinic. Please click below to confirm that you are happy for the information to be included on the database. We will be collecting information about you throughout your treatment.

Signature …… NAME (Print) ……

Date ……

In some cases it is easier to send you follow up questionnaires by email. Don't worry, we will only send emails when you are due a follow up questionnaire, so this will be a maximum of three questionnaires over two years. If you give consent to receive email questionnaires, please complete the details below:

I consent to email contact.

Email address: _____

Signature …..……

1. DEMOGRAPHIC INFORMATION

a) Age: _____ Years

b) What is your Height? _____ Metres

c) What is your current weight? _____ Kilograms

d) Are you currently trying to get pregnant? YES ☐ NO ☐

If yes, for how long (months)? _____

e) Have you had a pregnancy since your endometriosis surgery? YES ☐ NO ☐

If yes, how many births have you had? _____

How many miscarriages have you had? _____

How many ectopic pregnancies have you had? _____

2. GENERAL QUESTION ABOUT YOUR PAIN

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 period')

Pre-menstrual pain (pain before periods)	Experienced: YES ☐ NO ☐ N/A ☐
Experienced slightly 1 2 3 4 5 6 7 8 9 10 Experienced severely	

Menstrual pain (pain during periods) ☐	Experienced: YES ☐ NO ☐ N/A
Experienced slightly 1 2 3 4 5 6 7 8 9 10 Experienced severely	

Non-cyclical pelvic pain (pain at any other time in the month)	Experienced: YES ☐ NO ☐
Experienced slightly 1 2 3 4 5 6 7 8 9 10 Experienced severely	

Pain during sexual intercourse ☐	Experienced: YES ☐ NO ☐ N/A

Experienced slightly									Experienced severely
1	2	3	4	5	6	7	8	9	10

Pain opening bowels during period Experienced: YES ☐ NO ☐ N/A

☐

Experienced slightly									Experienced severely
1	2	3	4	5	6	7	8	9	10

Pain opening bowels at other times Experienced: YES ☐ NO ☐ N/A

☐

Experienced slightly									Experienced severely
1	2	3	4	5	6	7	8	9	10

Bladder pain or pain passing urine Experienced: YES ☐ NO ☐ N/A

☐

Experienced slightly									Experienced severely
1	2	3	4	5	6	7	8	9	10

3. Other Symptoms

Fatigue Experienced: YES ☐ NO ☐ N/A

☐

Experienced slightly									Experienced severely
1	2	3	4	5	6	7	8	9	10

Heavy periods that affect daily life Experienced: YES ☐ NO ☐ N/A ☐

Which of these pain symptoms is most bothersome (this may not be the one that is most severe)? Please tick one.

Before periods	☐
During periods	☐
At any time of the month	☐
During sexual intercourse	☐
Opening bowels during periods	☐

Opening bowels at any other time of the month ☐

Bladder pain or pain passing urine during periods ☐

Bladder pain or pain passing urine at any other times ☐

4. Information about Bowel function

a) Do you have a stoma? YES ☐ NO ☐

i) If no, do you have frequent bowel movements?

Never	A little of the time	Some of the time	Most of the time	All of the time
☐	☐	☐	☐	☐

ii) If no, do you have urgent bowel movements?

Never	A little of the time	Some of the time	Most of the time	All of the time
☐	☐	☐	☐	☐

iii) If no, do you have sensation of incomplete emptying of the bowel?

Never	A little of the time	Some of the time	Most of the time	All of the time
☐	☐	☐	☐	☐

iv) If no, do you have constipation?

Never	A little of the time	Some of the time	Most of the time	All of the time
☐	☐	☐	☐	☐

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

Never	A little of the time	Some of the time	Most of the time	All of the time	No Periods
☐	☐	☐	☐	☐	☐

c) Do you experience bloating?

Never	A little of the time	Some of the time	Most of the time	All of the time	No Periods

☐	☐	☐	☐	☐	☐

5. Medical Therapy

a) Since your endometriosis surgery, have you taken any of the following treatments for your endometriosis? (Tick all that apply)

a. Hormonal contraception

i. Combined oral contraceptive pill YES ☐ NO

☐

ii. Progestogen only pill (*mini pill or Desogesterel only pill*) YES ☐ NO

☐

iii. Dienogest YES ☐ NO

☐

iv. Progestogen injection (*E.g Depo, Provera, Sayana Press*) YES ☐ NO

☐

v. Contraceptive Progestogen Implant (*E.g Nexplanon*) YES ☐ NO

☐

vi. Hormonal coils (*E.g Mirena, Levosert*) YES ☐ NO

☐

b. GnRH analogues +/- HRT

i. GnRH agonist (*E.g. Goserelin, Buserelin, decapeptyl, Prostap, Naferelin, Lupron, zoladex - as injection, implant or nasal spray*) YES ☐ NO

☐

ii. GnRH antagonist (*E.g elagolix, relugolix, linzagolix, Ryeqo, Yselty*) YES ☐ NO

☐

iii. HRT (*patch, tablet or spray*) YES ☐ NO

☐

c. Aromatase inhibitors

i. Aromatase inhibitors (*E.g Letrozole, Anastrozole, Exemestane*) YES ☐ NO

☐

6. Painkillers

a) Are you currently (within the last three months) taking any of the following treatments for your endometriosis? (Tick all that apply)

- ☐ Paracetamol
- ☐ NSAID anti-inflammatories (*E.g. Ibuprofen, Diclofenac, Mefenamic acid)*
- ☐ Opiates (*E.g. Tramadol, Dihydrocodeine, Oramorph)*
- ☐ Cannabinoids
- ☐ Co-codamol

7. Neuromodulators

a) Do you take any of the following neuromodulators? (Tick all that apply)

- ☐ Amytriptiline
- ☐ Nortriptyline
- ☐ Gabapentin
- ☐ Pregablin
- ☐ Duloxetine

8. Other Treatments

a) Do you use any other treatment/strategy for the management of pain due to endometriosis? (Tick all that apply)

- ☐ Acupuncture
- ☐ Cognitive behavioural therapy
- ☐ Tens machine
- ☐ Physiotherapy
- ☐ Mindfulness
- ☐ Dietary modifications
- ☐ Heat
- ☐ Exercise

☐ Other (please describe)

9. Satisfaction

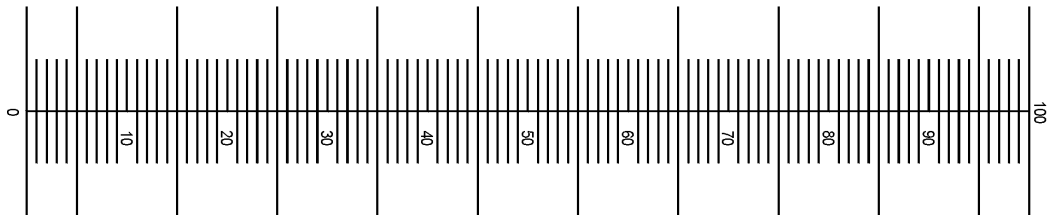
a) How satisfied are you with the surgery you have received for your endometriosis?

Totally satisfied	Mostly satisfied	Somewhat satisfied	Somewhat dissatisfied	Mostly dissatisfied	Totally dissatisfied
☐	☐	☐	☐	☐	☐

10. Questions about your general health?

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)

ENDOMETRIOSIS HEALTH PROFILE QUESTIONNAIRE (EHP-5)

PART 1: CORE QUESTIONNAIRE

DURING THE LAST 4 WEEKS,
HOW OFTEN, BECAUSE OF YOUR ENDOMETRIOSIS, HAVE YOU...

		Never	Rarely	Sometimes	Often	Always
1.	Found it difficult to walk because of the pain?	☐	☐	☐	☐	☐
2.	Felt as though your symptoms are ruling your life?	☐	☐	☐	☐	☐
3.	Had mood swings?	☐	☐	☐	☐	☐
4.	Felt others do not understand what you are going through?	☐	☐	☐	☐	☐
5.	Felt your appearance has been affected?	☐	☐	☐	☐	☐

Please check that you have ***ticked one box for each question***.

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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.