Pelvic Pain Assessment Form

Physician: ___________________________  Date: _____________________________

This assessment form is intended to assist the clinician with the initial patient assessment and is not meant to be a diagnostic tool.

Contact Information
Name:___________________________________    Birth Date:_________________ Chart Number:________________
Phone:  Work: ____________________________ Home: ____________________ Cell: _______________________
Referring Provider’s Name and Address: __________________________________________________________________

Information About Your Pain
Please describe your pain problem (use a separate sheet of paper if needed) :_______________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

What do you think is causing your pain?
Is there an event that you associate with the onset of your pain? □ Yes □ No  If so, what?_________________________
How long have you had this pain?  ____ years  ____ months

For each of the symptoms listed below, please “bubble in” your level of pain over the last month using a 10-point scale:
0 - no pain         10 – the worst pain imaginable
How would you rate your pain?  0  1  2  3  4  5  6  7  8  9  10
  Pain at ovulation (mid-cycle) 0  0  0  0  0  0  0  0  0  0  0
  Pain just before period 0  0  0  0  0  0  0  0  0  0  0
  Pain (not cramps) before period 0  0  0  0  0  0  0  0  0  0  0
  Deep pain with intercourse 0  0  0  0  0  0  0  0  0  0  0
  Pain in groin when lifting 0  0  0  0  0  0  0  0  0  0  0
Pelvic pain lasting hours or days after intercourse 0  0  0  0  0  0  0  0  0  0  0
  Pain when bladder is full 0  0  0  0  0  0  0  0  0  0  0
  Muscle / joint pain 0  0  0  0  0  0  0  0  0  0  0
  Level of cramps with period 0  0  0  0  0  0  0  0  0  0  0
  Pain after period is over 0  0  0  0  0  0  0  0  0  0  0
  Burning vaginal pain after sex 0  0  0  0  0  0  0  0  0  0  0
  Pain with urination 0  0  0  0  0  0  0  0  0  0  0
  Backache 0  0  0  0  0  0  0  0  0  0  0
  Migraine headache 0  0  0  0  0  0  0  0  0  0  0
  Pain with sitting 0  0  0  0  0  0  0  0  0  0  0

Provider Comments
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

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(205) 877-2950  www.pelvic pain.org  (800)624-9676 (if in the U.S.)
### Information About Your Pain

What types of treatments/providers have you tried in the past for your pain?

<table>
<thead>
<tr>
<th>Treatment/Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Anesthesiologist</td>
</tr>
<tr>
<td>Anti-seizure medications</td>
</tr>
<tr>
<td>Antidepressants</td>
</tr>
<tr>
<td>Biofeedback</td>
</tr>
<tr>
<td>Botox injection</td>
</tr>
<tr>
<td>Contraceptive pills/patch/ring</td>
</tr>
<tr>
<td>Danazol (Danocrine)</td>
</tr>
<tr>
<td>Depo-provera</td>
</tr>
<tr>
<td>Gastroenterologist</td>
</tr>
<tr>
<td>Gynecologist</td>
</tr>
<tr>
<td>Nutrition/diet</td>
</tr>
<tr>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Psychotherapy</td>
</tr>
<tr>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Rheumatologist</td>
</tr>
<tr>
<td>Skin magnets</td>
</tr>
<tr>
<td>Surgery</td>
</tr>
<tr>
<td>TENS unit</td>
</tr>
<tr>
<td>Trigger point injections</td>
</tr>
<tr>
<td>Urologist</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

### Pain Maps

Please shade areas of pain and write a number from 1 to 10 at the site(s) of pain. (10 = most severe pain imaginable)

#### Vulvar / Perineal Pain
*(pain outside and around the vagina and anus)*

If you have vulvar pain, shade the painful areas and write a number from 1 to 10 at the painful sites. (10 = most severe pain imaginable)

Is your pain relieved by sitting on a commode seat?  □ Yes  □ No

Right: □ Yes  □ No  
Left: □ Yes  □ No
What physicians or health care providers have evaluated or treated you for **chronic pelvic pain**?

<table>
<thead>
<tr>
<th>Physician / Provider</th>
<th>Specialty</th>
<th>City, State, Phone</th>
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</thead>
<tbody>
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</tbody>
</table>

**Demographic Information**

Are you (check all that apply):

- ☐ Married
- ☐ Widowed
- ☐ Separated
- ☐ Committed Relationship
- ☐ Single
- ☐ Remarried
- ☐ Divorced

Who do you live with? ________________________________________________________________

Education:

- ☐ Less than 12 years
- ☐ High School graduate
- ☐ College degree
- ☐ Postgraduate degree

What type of work are you trained for? __________________________________________________

What type of work are you doing? _____________________________________________________

**Surgical History**

Please list all surgical procedures you have had **related to this pain**:

<table>
<thead>
<tr>
<th>Year</th>
<th>Procedure</th>
<th>Surgeon</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Please list all **other** surgical procedures:

<table>
<thead>
<tr>
<th>Year</th>
<th>Procedure</th>
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**Provider Comments**

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
**Medications**

Please list **pain medication** you have taken for your pain condition in the past 6 months, and the providers who prescribed them (use a separate page if needed):

<table>
<thead>
<tr>
<th>Medication / dose</th>
<th>Provider</th>
<th>Did it help?</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
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<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
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<tr>
<td></td>
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<td>☐ Yes ☐ No ☐ Currently taking</td>
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<td>☐ Yes ☐ No ☐ Currently taking</td>
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<td>☐ Yes ☐ No ☐ Currently taking</td>
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<td>☐ Yes ☐ No ☐ Currently taking</td>
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<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
</tbody>
</table>

Please list all **other medications** you are presently taking, the condition, and the provider who prescribed them (use a separate page if needed):

<table>
<thead>
<tr>
<th>Medication / dose</th>
<th>Provider</th>
<th>Medical Condition</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

**Obstetrical History**

How many pregnancies have you had? ______
Resulting in (#): ______ Full 9 months ______ Premature ______ Miscarriage / Abortion ______ Living children

Where there any complications during pregnancy, labor, delivery, or post partum?

☐ 4° Episiotomy ☐ C-Section ☐ Vacuum ☐ Post-partum hemorrhaging
☐ Vaginal laceration ☐ Forceps ☐ Medication for bleeding ☐ Other __________

**Family History**

Has anyone in your family had:

☐ Fibromyalgia ☐ Chronic pelvic pain ☐ Irritable bowel syndrome
☐ Depression ☐ Interstitial Cystitis ☐ Other Chronic Condition __________
☐ Endometriosis ☐ Cancer, Type(s) __________

**Medical History**

Please list any medical problems / diagnoses __________________________
____________________________________________________________________
____________________________________________________________________

Allergies (including latex allergy) __________________________
Who is your primary care provider? __________________________

Have you ever been hospitalized for anything besides childbirth? ☐ Yes ☐ No If yes, please explain __________

Have you had major accidents such as falls or a back injury? ☐ Yes ☐ No

Have you ever been treated for depression? ☐ Yes ☐ No Treatments: ☐ Medication ☐ Hospitalization ☐ Psychotherapy

Birth control method: ☐ Nothing ☐ Pill ☐ Vasectomy ☐ Vaginal ring ☐ Depo provera
☐ Condom ☐ IUD ☐ Hysterectomy ☐ Diaphragm ☐ Tubal Sterilization
☐ Other __________________________
### Menstrual History

How old were you when your menses started? _________  
Are you still having menstrual periods? □ Yes  □ No

**Answer the following only if you are still having menstrual periods.**

- Periods are: □ Light  □ Moderate  □ Heavy  □ Bleed through protection
- How many days between your periods? ____________
- How many days of menstrual flow? _______________
- Date of first day of last menstrual period ____________
- Do you have any pain with your periods? □ Yes  □ No
  - Does pain start the day flow starts? □ Yes  □ No  Pain starts ______ days before flow
  - Are periods regular? □ Yes  □ No
  - Do you pass clots in menstrual flow? □ Yes  □ No

### Gastrointestinal / Eating

Do you have nausea? □ No  □ With pain  □ Taking medications  □ With eating  □ Other
Do you have vomiting? □ No  □ With pain  □ Taking medications  □ With eating  □ Other
Have you ever had an eating disorder such as anorexia or bulimia? □ Yes  □ No
Are you experiencing rectal bleeding or blood in your stool? □ Yes  □ No
Do you have increased pain with bowel movements? □ Yes  □ No

The following questions help to diagnose irritable bowel syndrome, a gastrointestinal condition, which may be a cause of pelvic pain.

**Do you have pain or discomfort that is associated with the following:**

- Change in frequency of bowel movement □ Yes  □ No
- Change in appearance of stool or bowel movement? □ Yes  □ No
- Does your pain improve after completing a bowel movement? □ Yes  □ No

### Health Habits

How often do you exercise? □ Rarely  □ 1-2 times weekly  □ 3-5 times weekly  □ Daily
What is your caffeine intake (number cups per day, include coffee, tea, soft drinks, etc)? □ 0  □ 1-3  □ 4-6  □ >6
How many cigarettes do you smoke per day? ____________  For how many years? ____________
Do you drink alcohol? □ Yes  □ No  Number of drinks per week ______
Have you ever received treatment for substance abuse? □ Yes  □ No
What is your use of recreational drugs? □ Never used  □ Used in the past, but not now  □ Presently using  □ No answer
□ Heroin  □ Amphetamines  □ Marijuana  □ Barbiturates  □ Cocaine  □ Other ____________
How would you describe your diet? (check all that apply) □ Well balanced  □ Vegan  □ Vegetarian  □ Fried food
□ Special diet ________________________ □ Other ________________________

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Urinary Symptoms
Do you experience any of the following?
- Loss of urine when coughing, sneezing, or laughing? □ Yes □ No
- Difficulty passing urine? □ Yes □ No
- Frequent bladder infections? □ Yes □ No
- Blood in the urine? □ Yes □ No
- Still feeling full after urination? □ Yes □ No
- Having to void again within minutes of voiding? □ Yes □ No

The following questions help to diagnose painful bladder syndrome, which may cause pelvic pain. Please circle the answer that best describes your bladder function and symptoms.

<table>
<thead>
<tr>
<th>Question</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How many times do you go to the bathroom <strong>DURING THE DAY</strong>...</td>
<td>3-6</td>
<td>7-10</td>
<td>11-14</td>
<td>15-19</td>
<td>20 or more</td>
</tr>
<tr>
<td>2. How many times do you go to the bathroom <strong>AT NIGHT</strong>...</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 or more</td>
</tr>
<tr>
<td>3. If you get up at night to void or empty your bladder does it bother you? Never</td>
<td>Mildly</td>
<td>Moderately</td>
<td>Severely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Are you sexually active? □ Yes □ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse? Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. If you have pain with intercourse, does it make you avoid sexual intercourse? Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you have pain associated with your bladder or in your pelvis (lower abdomen, labia, vagina, urethra, perineum)? Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Do you have urgency after voiding? Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. If you have pain, is it usually Never</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Does your pain bother you? Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. If you have urgency, is it usually Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Does your urgency bother you? Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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KCI ____ Not Indicated  ____ Positive  ____ Negative
### Coping Mechanisms

Who are the people you talk to concerning your pain, or during stressful times?

- Spouse / Partner
- Relative
- Support group
- Doctor / Nurse
- Friend
- Mental Health provider
- Clergy
- I take care of myself

How does your partner deal with your pain?

- Doesn’t notice when I’m in pain
- Takes care of me
- Not applicable
- Withdraws
- Feels helpless
- Gets angry

What helps your pain?

- Meditation
- Relaxation
- Lying down
- Music
- Massage
- Ice
- Heating pad
- Hot bath
- Pain medication
- Laxatives / Enema
- Injection
- TENS unit
- Bowel movement
- Emptying bladder
- Nothing
- Other

What makes your pain worse?

- Intercourse
- Orgasm
- Stress
- Full meal
- Bowel movement
- Full bladder
- Urination
- Standing
- Walking
- Exercise
- Time of day
- Weather
- Contact with clothing
- Coughing / sneezing
- Not related to anything
- Other

Of all the problems or stresses in your life, how does your pain compare in importance?

- The most important problem
- Just one of many problems

---

### Sexual and Physical Abuse History

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check an answer for both as a child and as an adult.

1a. Has anyone ever exposed the sex organs of their body to you when you did not want it?
    - Never
    - Seldom
    - Occasionally
    - Often
    - Yes
    - No

1b. Has anyone ever threatened to have sex with you when you did not want it?
    - Never
    - Seldom
    - Occasionally
    - Often
    - Yes
    - No

1c. Has anyone ever touched the sex organs of your body when you did not want this?
    - Never
    - Seldom
    - Occasionally
    - Often
    - Yes
    - No

1d. Has anyone ever made you touch the sex organs of their body when you did not want this?
    - Never
    - Seldom
    - Occasionally
    - Often
    - Yes
    - No

1e. Has anyone forced you to have sex when you did not want this?
    - Never
    - Seldom
    - Occasionally
    - Often
    - Yes
    - No

1f. Have you had any other unwanted sexual experiences not mentioned above?
    - Never
    - Seldom
    - Occasionally
    - Often
    - Yes
    - No

If yes, please specify ________________________________

2. When you were a child (13 or younger), did an older person do the following?
   a. Hit, kick, or beat you?       - Never       - Seldom       - Occasionally       - Often
   b. Seriously threaten your life? - Never       - Seldom       - Occasionally       - Often

3. Now that you are an adult (14 or older), has any other adult done the following?
   a. Hit, kick, or beat you?       - Never       - Seldom       - Occasionally       - Often
   b. Seriously threaten your life? - Never       - Seldom       - Occasionally       - Often

**Short-Form McGill**

The words below describe average pain. Place a check mark (✓) in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of the pain in your pelvic area only.

What does your pain feel like?

<table>
<thead>
<tr>
<th>Type</th>
<th>None (0)</th>
<th>Mild (1)</th>
<th>Moderate (2)</th>
<th>Severe (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Throbbing</td>
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<tr>
<td>Shooting</td>
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<tr>
<td>Stabbing</td>
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<tr>
<td>Sharp</td>
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<td>Cramping</td>
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<tr>
<td>Gnawing</td>
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<tr>
<td>Hot-Burning</td>
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<td></td>
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<tr>
<td>Aching</td>
<td></td>
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<tr>
<td>Heavy</td>
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<tr>
<td>Tender</td>
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<tr>
<td>Splitting</td>
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<tr>
<td>Tiring-Exhausting</td>
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<tr>
<td>Sickening</td>
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<tr>
<td>Fearful</td>
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<tr>
<td>Punishing-Cruel</td>
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**Pelvic Varicosity Pain Syndrome Questions**

- Is your pelvic pain aggravated by prolonged physical activity?  □ Yes  □ No
- Does your pelvic pain improve when you lie down?  □ Yes  □ No
- Do you have pain that is deep in the vagina or pelvis during sex?  □ Yes  □ No
- Do you have pelvic throbbing or aching after sex?  □ Yes  □ No
- Do you have pelvic pain that moves from side to side?  □ Yes  □ No
- Do you have sudden episodes of severe pelvic pain that come and go?  □ Yes  □ No

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(205) 877-2950  www.pelvic pain.org  (800)624-9676 (if in the U.S.)
Physical Examination – For Physician Use Only

Name:___________________________________________  Chart Number:_____________________________

Date of Exam:_______________________  Height:________  Weight:________   BMI:________

BP:_________   HR: ________   Temp:________   Resp:________   LMP:________

ROS, PFSH Reviewed:  □ Yes  □ No

Physician Signature:________________________________________

General Appearance:  □ Well-appearing  □ Ill-appearing   □ Tearful   □ Depressed

□ Normal weight  □ Underweight   □ Overweight   □ Abnormal Gait

NOTE: Mark “Not Examined” as N/E

<table>
<thead>
<tr>
<th>HEENT</th>
<th>WNL</th>
<th>Lungs</th>
<th>WNL</th>
<th>Heart</th>
<th>WNL</th>
<th>Breasts</th>
<th>WNL</th>
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<tbody>
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</tbody>
</table>

Abdomen

□ Non-tender  □ Tender  □ Incisions  □ Trigger Points

□ Inguinal Tenderness  □ Inguinal Bulge  □ Suprapubic Tenderness  □ Ovarian Point Tenderness

□ Mass  □ Guarding  □ Rebound  □ Distention

□ Other

---

Trigger Points

Surgical Scars

Other Findings

Back

□ Non-tender  □ Tender  □ Alteration in posture  □ SI joint rotation

□ Alteration in posture

Lower Extremities

□ WNL  □ Edema  □ Varicosities  □ Neuropathy  □ Length Discrepancy

Neuropathy

□ Iliohypogastric  □ Ilioinguinal  □ Genitofemoral  □ Pudendal  □ Altered sensation

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Fibromyalgia / Back / Buttock

External Genitalia

- WNL
- Erythema
- Discharge
- Q-tip test (show on diagram)
- Tenderness (show on diagram)

Q-tip Test (score each circle 0-4) **Total Score** _______  
Other Findings ________________________________

Vagina

- WNL
- Wet prep:__________________________
- Local tenderness________________________
- Vaginal mucosa________________________
- Discharge___________________
  Cultures: GC Chlamydia Fungal Herpes
- Vaginal Apex Tenderness (post hysterectomy – show on diagram)

Transverse apex closure  Vertical apex closure

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(205) 877-2950  www.pelvicpain.org  (800)624-9676 (if in the U.S.)
### Unimanual Exam
- □ WNL
- □ Introitus
- □ Uterine-cervical junction
- □ Urethra
- □ Bladder
- □ R ureter
- □ R inguinal
- □ Muscle awareness
- □ Cervix
- □ Cervical motion
- □ Parametrium
- □ Vaginal cuff
- □ Cul-de-sac
- □ L ureter
- □ L inguinal
- □ Clitoral tenderness

### Rank muscle tenderness on 0-4 scale
- □ R obturator
- □ L obturator
- □ R piriformis
- □ L piriformis
- □ R pubococcygeus
- □ L pubococcygeus
- □ Total pelvic floor score
- □ Anal Sphincter

### Bimanual Exam

<table>
<thead>
<tr>
<th>Uterus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tender</td>
</tr>
<tr>
<td>Position:</td>
</tr>
<tr>
<td>Anterior</td>
</tr>
<tr>
<td>Size:</td>
</tr>
<tr>
<td>Normal</td>
</tr>
<tr>
<td>Contour:</td>
</tr>
<tr>
<td>Regular</td>
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<tr>
<td>Consistency:</td>
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<tr>
<td>Firm</td>
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<tr>
<td>Mobility:</td>
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<tr>
<td>Mobile</td>
</tr>
<tr>
<td>Support:</td>
</tr>
<tr>
<td>Mobile</td>
</tr>
</tbody>
</table>

### Adnexal Exam

Right:  | Left:  |
□ Absent | □ Absent |
□ WNL | □ WNL |
□ Tender | □ Tender |
□ Fixed | □ Fixed |
□ Enlarged _______ cm | □ Enlarged _______ cm

### Rectovaginal Exam
- □ WNL
- □ Nodules
- □ Tenderness
- □ Mucosal pathology
- □ Guaiac positive
- □ Enlarged cm
- □ Not examined

### Assessment:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

### Diagnostic Plan:

__________________________________________________________________________________________
__________________________________________________________________________________________
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### Therapeutic Plan:

__________________________________________________________________________________________
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