

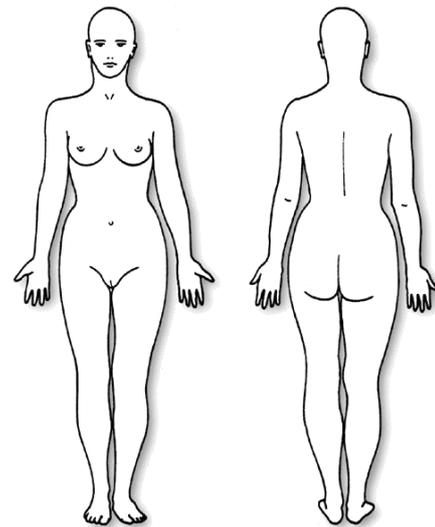
Keeping a record of your pain and symptoms can help you and your doctor to manage your symptoms, could help with a diagnosis. It provides an efficient way to communicate with your doctor in the short timeframe you are in their rooms. Page one is a list of questions, page two is a diary for one week. Print the second page multiple times to keep your diary for longer.

**Date of last period:**    \_/\_/\_\_\_

1.     What age were you when you started your periods?
2.     Are your periods regular e.g. every month? Length of your period? Length of your cycle?
4.     Would you describe it as light, medium, heavy or very heavy?
5.     Do you bleed between periods?

**Pain**

1.     Do you get pain during your period?
2.     Do you get pain at other times of the month? If so, when?
3.     Where do you get this pain? Can you mark on the diagram exactly where you experience ALL pain?
4.     Do you get pain during or after intercourse?
5.     What makes your pain worse?
7.     Circle the words that best describe your pain.



Stabbing      Spasm      Burning Dull      Aching      Sharp      Cramping  
                   Constant      Throbbing      Random      Agonising      Shooting

**Symptoms:**

1.     Do you have pain or bleed when you have a bowel movement? Is this worse during your period?
2.     Do you have pain or bleed when you urinate? Is this worse during your period?
3.     Do you feel bloated? Is this worse during your period?
4.     Are you physically tired? Do you get more tired during your period?
5.     Do you feel sick, vomit or faint during your period

*Please answer as honestly as you can – your answers will be invaluable for your doctor. Provide details if you can, it does help. Even if it doesn't seem relevant to you it may mean something to your doctor and help you get the answers and treatment you are searching for.*

Date / /2007	Are you on your period?	Describe your pain* and where it is	How does it feel** and how long does it last? e.g. 3 hours	Do you have any other symptoms? e.g. bowel or urinary problems	Did you take or do anything to help with the symptoms? Results	What affect did it have on you?***
Mon						
Tues						
Wed						
Thurs						
Fri						
Sat						
Sun						

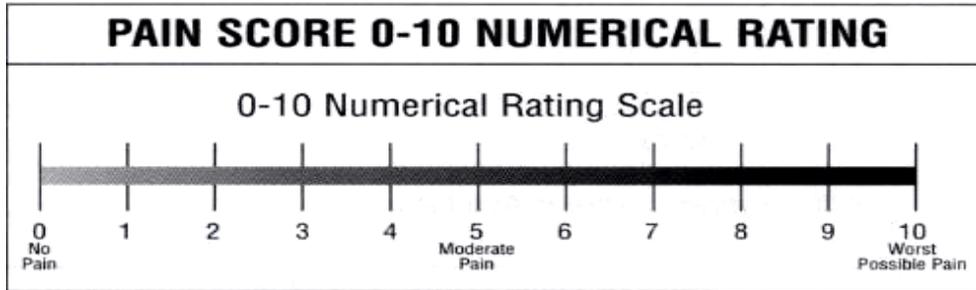
\* Please rate your pain on a scale of 1-10. Where 1 = tolerable and 10 = the worst pain imaginable

\*\* Please use the words listed on question 6 under 'pain', or add your own

\*\*\* Please state whether these symptoms affected your work, education, relationships, social activities, sleep, exercise, food intake, sex life, stress levels, quality of life that day

## RATE YOUR PAIN

The 1 – 10 rating scale for pain.



Choose a number from 0 to 10 that best describes their current pain. 0 would mean 'No pain' and 10 would mean 'Worst possible pain'.

## ANOTHER WAY TO RATE YOUR PAIN

You may choose to rate your pain in a different way to the 1 – 10 scale. If you do please ensure you show your doctor the scale you choose to use.



Choose the face that best describes how they feel. The far left face indicates 'No hurt' and the far right face indicates 'Hurts worst'. Document number below the face chosen.

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