PREPARING TO SEE A NEW HEALTHCARE PROVIDER FOR CHRONIC PELVIC PAIN

When you are getting ready to see a new healthcare professional, start by considering your goals in seeking care. Your goals may include:

- Decreasing pain
- Increasing physical activity
- Enjoying sexual activity
- Correcting bladder and bowel disorder
- Improving quality of life

Be ready to communicate your goals to the provider so they can address your expectations and tailor your treatment to these goals if possible. To make an effective treatment plan, a provider will need a detailed history of your symptoms and treatments. There are several ways in which your history can be gathered:

**Health Questionnaire:** The provider may ask you to complete a form before your visit. These forms typically include questions about your pain, other bothersome symptoms, your thoughts and feelings about pain, and the impact pain has on your activities, mood, and relationships. While these forms are sometimes long, the information you supply helps make your visit more efficient. When scheduling your appointment, ask whether there will be a questionnaire. If you can complete it fully before your appointment, you will be better prepared for your visit.

**Expect Questions:** The provider needs to hear your story in your own words. They are likely to ask many questions to have a more complete understanding of your symptoms. Even if you have a written summary or have completed a detailed questionnaire, you and the provider will need to talk about your pain experience.

**Treatment Records:** Medical records help providers better understand diagnoses and treatments you have received. Records detailing all past pelvic, abdominal, and other surgeries and procedures are particularly important. Reports from recent imaging and office visits are also helpful. Before your appointment, gather the following documents:

- **Operative reports:** Describe what was found and done during surgery.
- **Procedure reports:** Describe procedures such as nerve block or colonoscopy.
Pathology reports: Describe microscopic findings of tissue removed.

Surgical photos: A picture is worth a thousand words!

Imaging reports: Describe findings of ultrasound, MRI, CT scans, etc.

Office notes: Describe evaluations, treatments, & outcomes from office visits

Be sure to sign a records release form so the staff can request records in advance of your visit. At least a week in advance, contact the office to confirm they have received the records.

**Medication Lists:** For each medication, include name, dose, time(s) you take it.

- Current medications: keep an updated list of all medications and bring it to every appointment. In addition to name, dose, and time you take it, include why you take it and approximately when you started it. Be sure to include over-the-counter medications, vitamins, and herbal supplements.
- Past medications: bring a list of all medications you have taken for pain. In addition to name and dose, include approximate dates you took the medication, whether and how much it helped, any side effects you experienced, and why you are no longer taking it.

**Treatment Team:** For each provider, include name, specialty, location, phone/fax numbers.

- Current providers: It is helpful for a new provider to know about all health care providers who you are seeing or are currently supplying any treatment including medications, procedures, physical therapy, and talk therapy.
- Past Providers: If possible, bring a list of any providers you have seen for your pain in the past but are no longer seeing.

If you can provide a printed copy of your records, you can avoid technical issues with electronic or fax transmission and ensure your new provider receives what they need. If you have only one copy of your records, the office should be able to make a copy for the provider to review. If you do not have a copy of your records, be sure to sign a records release form so the staff can request records in advance of your visit. At least a week in advance, contact the office to confirm they have received the records. Having records organized by date and labeled by type of treatment will allow the provider to find information more quickly and understand what has already been done. This understanding helps greatly with creating the most effective treatment plan for you.

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