

San Diego Sexual Medicine

Name

Date

McGILL GENITAL PAIN QUESTIONNAIRE

Please complete all questions regardless of presence or absence of genital pain.

1. Please check in the appropriate column the degree to which you experienced each type of pain.

	<u>NONE</u>	<u>MILD</u>	<u>MODERATE</u>	<u>SEVERE</u>
1. THROBBING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. SHOOTING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. STABBING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. SHARP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. CRAMPING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. GNAWING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. HOT-BURNING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. ACHING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. HEAVY	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
10. TENDER	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
11. SPLITTING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
12. TIRING-EXHAUSTING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
13. SICKENING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
14. FEARFUL	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
15. PUNISHING-CRUEL	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

2. Please tick along scale below to rate severity of pain.

NO PAIN ----- WORST PAIN

3. Please check in appropriate columns the overall intensity of pain.

PPI

- 0 NO PAIN
- 1 MILD
- 2 DISCOMFORTING
- 3 DISTRESSING
- 4 HORRIBLE
- 5 EXCRUCIATING