	Participant ID: _____	Pin # _____
	Discovery Site: _____	Clinical Center _____
	CRF Date: ____/____/____	Visit #: _____

FEMALE GENITOURINARY PAIN INDEX
Female Participant completes this form at ALL Clinic and Online contacts.

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

a. Entrance to vagina	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
b. Vagina	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
c. Urethra	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
d. Below your waist, in you pubic or bladder area	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No

2. In the last week, have you experienced:

a. Pain or burning during urination?	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
b. Pain or discomfort during or after sexual intercourse?	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
c. Pain or discomfort as your bladder fills?	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
d. Pain or discomfort relieved by voiding?	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No

3. How often have you had pain or discomfort in any of these areas over the last week?

	<input type="checkbox"/> ₀ Never	
	<input type="checkbox"/> ₁ Rarely	
	<input type="checkbox"/> ₂ Sometimes	
	<input type="checkbox"/> ₃ Often	
	<input type="checkbox"/> ₄ Usually	
	<input type="checkbox"/> ₅ Always	

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?


<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10
No Pain					Pain as bad as you can imagine					

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

	<input type="checkbox"/> ₀ Not at all	
	<input type="checkbox"/> ₁ Less than 1 time in 5	
	<input type="checkbox"/> ₂ Less than half the time	
	<input type="checkbox"/> ₃ About half the time	
	<input type="checkbox"/> ₄ More than half the time	
	<input type="checkbox"/> ₅ Almost always	

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

	<input type="checkbox"/> ₀ Not at all	
	<input type="checkbox"/> ₁ Less than 1 time in 5	
	<input type="checkbox"/> ₂ Less than half the time	
	<input type="checkbox"/> ₃ About half the time	
	<input type="checkbox"/> ₄ More than half the time	
	<input type="checkbox"/> ₅ Almost always	

	Participant ID: _____	Pin # _____
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FEMALE GENITOURINARY PAIN INDEX

Female Participant completes this form at **ALL Clinic and Online contacts.**

- | | |
|---|--|
| 7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week? | <input type="checkbox"/> ₀ None
<input type="checkbox"/> ₁ Only a little
<input type="checkbox"/> ₂ Some
<input type="checkbox"/> ₃ A lot |
| 8. How much did you think about your symptoms, over the last week? | <input type="checkbox"/> ₀ None
<input type="checkbox"/> ₁ Only a little
<input type="checkbox"/> ₂ Some
<input type="checkbox"/> ₃ A lot |
| 9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that? | <input type="checkbox"/> ₀ Delighted
<input type="checkbox"/> ₁ Pleased
<input type="checkbox"/> ₂ Mostly satisfied
<input type="checkbox"/> ₃ Mixed (about equally satisfied and dissatisfied)
<input type="checkbox"/> ₄ Mostly dissatisfied
<input type="checkbox"/> ₅ Unhappy
<input type="checkbox"/> ₆ Terrible |

Scoring

- | | |
|--|----------------------|
| 10. Pain subscale: Total of items 1a, 1b, 1c, 1d, 2a, 2b, 2c, 2d, 3, and 4 | = _____ (range 0-23) |
| 11. Urinary subscale: Total of items 5 and 6 | = _____ (range 0-10) |
| 12. QOL Impact: Total of items 7, 8, and 9 | = _____ (range 0-12) |
| 13. Total score: Sum of subscale scores | = _____ (range 0-45) |