



**CENTER for WOMEN'S HEALTH**

*A National Center of Excellence in Women's Health*

# Program in Vulvar Health



## Patient Demographics

**Date:** \_\_\_\_\_

Title: \_\_\_\_\_ First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

**Medical Record #** \_\_\_\_\_

**Social Security #** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Language: \_\_\_\_\_

Can we leave a confidential message on your home phone?

Yes \_\_\_\_\_ No \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_\_

Insurance Provider: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Provider List

**Who referred you?** \_\_\_\_\_

**Specialty:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

FAX \_\_\_\_\_

Would you like us to send copies of your visit to any other doctors? Yes \_\_\_\_\_ No \_\_\_\_\_

Provider	Address	Phone	Specialty

# Symptom Questionnaire

1. My vulvar condition began when I was \_\_\_\_\_ years old. This was \_\_\_\_\_ years ago.
2. Based on a scale of 0 (no symptoms) to 10 (worst symptoms) – what is your general level of vulvar discomfort?

Please mark the following lines to describe the level of discomfort:

**Vulvar Pain Today:**

0 ----- 10  
NONE WORST

**Pain During/After Sexual Touch:**

0 ----- 10  
NONE WORST

3. In addition to the above, which describes your problem?

Itching

Itch without discharge NO \_\_\_\_\_ YES \_\_\_\_\_

Itch with discharge NO \_\_\_\_\_ YES \_\_\_\_\_

Pain, Burning, Rawness

Constantly NO \_\_\_\_\_ YES \_\_\_\_\_

Only with specific touch NO \_\_\_\_\_ YES \_\_\_\_\_

Chronic abnormal vaginal discharge? NO \_\_\_\_\_ YES \_\_\_\_\_

Skin splits:

Spontaneous splits NO \_\_\_\_\_ YES \_\_\_\_\_

Splits just with intercourse NO \_\_\_\_\_ YES \_\_\_\_\_

Have you noted any skin changes: NO \_\_\_\_\_ YES \_\_\_\_\_

Where \_\_\_\_\_

Is the problem located in a specific area of your vulva? NO \_\_\_\_\_ YES \_\_\_\_\_

Where \_\_\_\_\_

Do symptoms come and go? NO \_\_\_\_\_ YES \_\_\_\_\_

It feels better when a cream or salve is applied to my vulva NO \_\_\_\_\_ YES \_\_\_\_\_

I wear cotton underwear NO \_\_\_\_\_ YES \_\_\_\_\_

I use mild soaps and detergents NO \_\_\_\_\_ YES \_\_\_\_\_

Symptoms limit the time I can sit, do activities, or do sports NO \_\_\_\_\_ YES \_\_\_\_\_

Dietary factors affect my pain NO \_\_\_\_\_ YES \_\_\_\_\_

I get bladder pain, urgency, frequency NO \_\_\_\_\_ YES \_\_\_\_\_

I cannot use tampons due to pain NO \_\_\_\_\_ YES \_\_\_\_\_

Speculums have always been painful NO \_\_\_\_\_ YES \_\_\_\_\_

My sister, mother, or daughter have my symptoms too NO \_\_\_\_\_ YES \_\_\_\_\_

I avoid intimate relationships due to pain NO \_\_\_\_\_ YES \_\_\_\_\_

## Symptoms continued:

Are you in a committed relationship? NO \_\_\_\_ YES \_\_\_\_

I became sexually active at age: \_\_\_\_\_

Number of lifetime sexual partners? \_\_\_\_ Less than 5 \_\_\_\_ Greater than 5

Number of Pregnancies \_\_\_\_ Vaginal deliveries \_\_\_\_ C-sections \_\_\_\_ Abortions \_\_\_\_

Are you having intercourse? \_\_\_\_ YES

\_\_\_\_ NO, due to pain \_\_\_\_ NO, due to my partner's health issues

\_\_\_\_ NO, the reason is: \_\_\_\_\_

My vulvar symptoms started 0-6 months after a new sexual partner: NO \_\_\_\_ YES \_\_\_\_

My relationship with my partner has become strained NO \_\_\_\_ YES \_\_\_\_

I/we use artificial lubricants NO \_\_\_\_ SOME \_\_\_\_ YES \_\_\_\_

I experience pain at the vaginal opening during sex NO \_\_\_\_ SOME \_\_\_\_ YES \_\_\_\_

My sexual desire has diminished due to my symptoms NO \_\_\_\_ SOME \_\_\_\_ YES \_\_\_\_

My symptoms affect my ability to be orgasmic NO \_\_\_\_ SOME \_\_\_\_ YES \_\_\_\_

My pain started after pregnancy NO \_\_\_\_ SOME \_\_\_\_ YES \_\_\_\_

I have been sexually abused NO \_\_\_\_ SOME \_\_\_\_ YES \_\_\_\_

**I have undergone a biopsy of the vulva** NO \_\_\_\_ YES \_\_\_\_

When: \_\_\_\_\_

By whom: \_\_\_\_\_

Results: \_\_\_\_\_

### Therapies I have tried:

### It helped?

Creams or ointments

1. _____	NO ____	YES ____
2. _____	NO ____	YES ____
3. _____	NO ____	YES ____

Oral Medicines

1. _____	NO ____	YES ____
2. _____	NO ____	YES ____
3. _____	NO ____	YES ____

### Other therapies I have tried:

Laser Interferon injections Hymen surgery

Sexual counseling Diet Restriction

Physical Therapy With whom? \_\_\_\_\_

Location: \_\_\_\_\_

Other counseling Type: \_\_\_\_\_

# Past Medical And Family History

For yourself, provide details and dates. For family members, please check if yes.

	Your History	MOTHER	FATHER	SIBLINGS	CHILDREN	OTHER
Stroke						
Heart disease						
Hypertension						
Asthma/emphysema						
Thyroid disease						
Diabetes						
Cancer Type:						
Alcoholism						
Drug Abuse						
Osteoporosis						
Arthritis						
Heartburn/Ulcer						
Bowel problems						
Depression/Anxiety						
Hepatitis						
Eating Disorders						

## Other health issues?

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## List any surgeries you have had:

Description	Date

## Gynecologic/Obstetric History

Age of first period \_\_\_\_\_ Date of last menstrual period \_\_\_\_/\_\_\_\_/\_\_\_\_  
History of Abnormal Paps? NO \_\_\_\_\_ YES \_\_\_\_\_ Treatment for HPV external warts or on cervix?  
Bleeding after menopause? NO \_\_\_\_\_ YES \_\_\_\_\_  
Are periods too heavy/too painful? NO \_\_\_\_\_ YES \_\_\_\_\_  
Contraception? NO \_\_\_\_\_ YES \_\_\_\_\_ Type: \_\_\_\_\_

### **Current Medications (prescribed or over the counter)/supplements/herbs:**

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

### **List Allergies to medications including reactions:**

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

### **Social History and habits:**

Single Partnered Married Divorced/Separated Widowed

Do you work outside the home? NO \_\_\_\_\_ YES \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Do you have children? NO \_\_\_\_\_ YES \_\_\_\_\_ Vaginal births # \_\_\_\_\_ Cesarean births # \_\_\_\_\_

Do you exercise? NO \_\_\_\_\_ YES \_\_\_\_\_ Type/frequency \_\_\_\_\_

Alcohol use: NO \_\_\_\_\_ YES \_\_\_\_\_ Amount per day/week \_\_\_\_\_

Tobacco use: NO \_\_\_\_\_ YES \_\_\_\_\_ Past use: NO \_\_\_\_\_ YES \_\_\_\_\_

# of cigarettes per day \_\_\_\_\_ Age began \_\_\_\_\_ Age quit \_\_\_\_\_

Drug use: NO \_\_\_\_\_ YES \_\_\_\_\_ Type/frequency \_\_\_\_\_