PROGRAM IN VULVAR HEALTH
PATIENT QUESTIONNAIRE

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Title: _____ First Name: _____ Last Name: _____

Medical Record # _____

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

OC1202

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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, and daughter have my symptoms too	☐ NO ☐ YES
I avoid intimate relationships due to pain	☐ NO ☐ YES

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Symptoms continued:

Are you in a committed relationship? ☐ No ☐ Yes
I am sexually active with ☐ men ☐ women ☐ Both
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 Medication
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: _____

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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/emphyse						
Thyroid disease						
Diabetes						
Cancer Type:						
Alcoholism						
Drug Abuse						
Osteoporosis						
Arthritis						
Heartburn/Ulcer						
Bowel problems						
Depression/Anxiet						
Hepatitis						
Eating Disorders						

Other health issues?

List any surgeries you have had:

Description Date

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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? NO ☐ YES ☐
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 Birth # _____ Cesarean birth # _____
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 _____

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GYNECOLOGIC/OBSTETRIC HISTORY (Continued)

Do you have any of the following symptoms currently?

Abdominal or pelvic pain
Constipation/diarrhea/blood in stool
Heartburn/trouble swallowing
Urine leakage
Joint/muscle pain
Breast lumps/nipple discharge
Shortness of breath
Visual/hearing problems
Weight loss, fevers, chills, sweats
Headaches — migraine or tension
Numbness/tingling/weakness of extremities
Depression, anxiety, irritability, trouble sleeping
Hot flashes/vaginal dryness

Other concerns? _____

_____

_____

_____

All other body symptoms are negative _____

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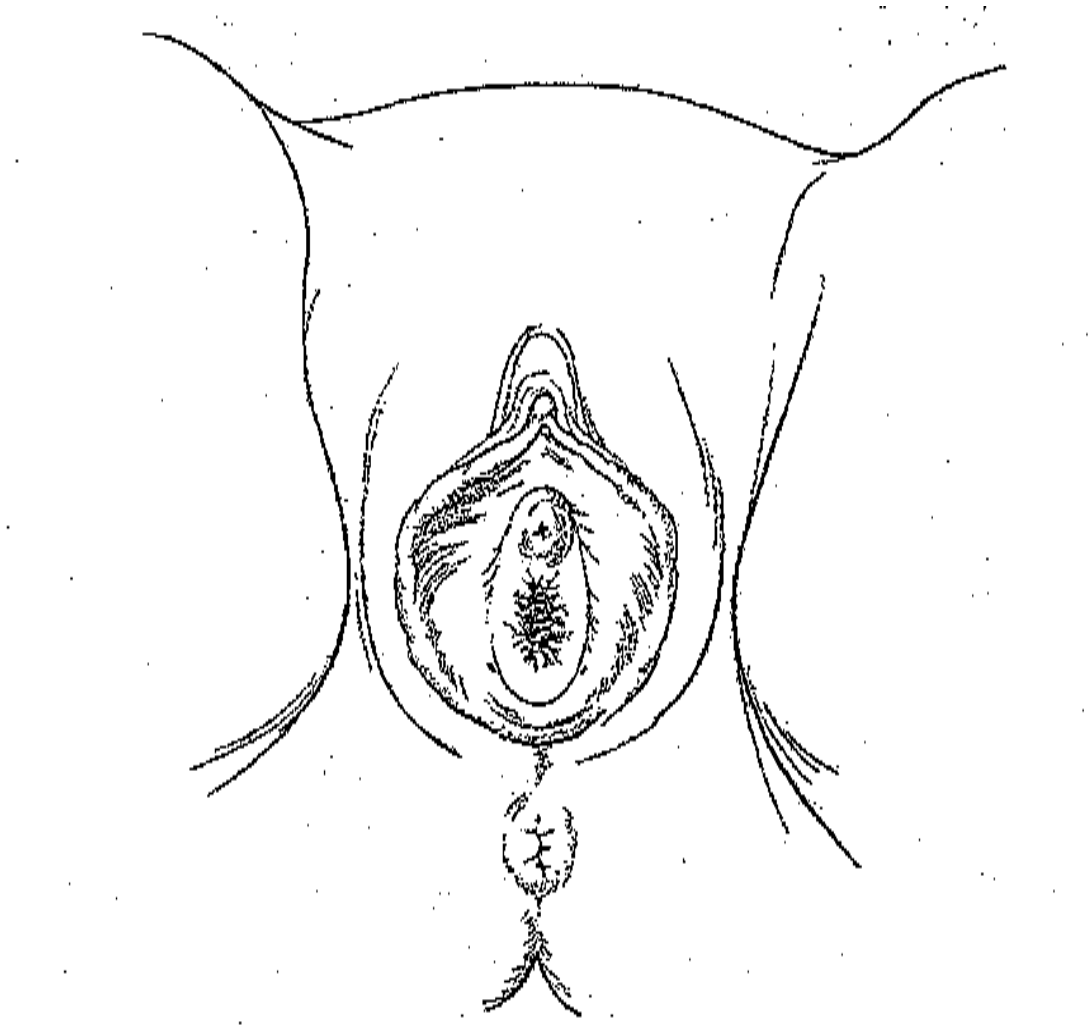
Physician's Physical Exam



Aqueous lidocaine reverses tenderness

Wet Mount: PH 3.5 4.0 4.5 5.0 >5.5

_____Inflammation _____ Immature Squames _____ Mature SQ

_____Lactobacillus _____ Hyphae _____ Clue cells _____ Spores

_____ Trich _____Other

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Patient Assessment:

1. Dermatologic
2. Infectious
3. Anatomic
4. Myfascial
5. Bartholins
6. Generalized Vulvodynia
7. Vestibulodynia
8. Sexual
   HSDD; Arousal;Orgasmic
9. Psychological
   Depression; OCD; Anxiety

Outside records reviewed _____

PLAN: _____

Aqueous Lidocaine 4% _____ Lidocaine 2% Gel _____ 5%Ointment _____

Culture bacterial _____ Culture fungal _____

Patient Referral to: _____

Patient handouts: _____

NVA brochure: _____

Counseling referral to: _____

Return for follow up: _____

Visit record faxed to referring MD: _____

Additional Dictation _____ **LENGTH OF VISIT _____ Minutes > 50% counseling**