Vulvar and Vaginal Disorders Questionnaire

Referring provider: ______________________________________

To whom should we send a report about this visit:

☐ My physician: ______________________________________  ☐ Don’t send anyone a report

Address/Phone: ______________________________________

Ethnicity (circle): Caucasian (white) Hispanic African American
                Pacific Islander Asian Other

Reason for Visit: In your own words, describe the vulvar or vaginal symptoms (discomfort) you are having: include when the symptoms started, what has been done about them, and what has worked or not worked

SYMPTOMS

Which vulvar/vaginal symptoms bother you most: (circle all that apply)

| Itching     | Sharp pain                      | Change in normal skin color |
| Burning     | Dull pain                       | Change in normal skin texture |
| Irritation  | Tearing/ripping pain            | Vaginal discharge           |
| Rawness     | Pain with sex                   | Abnormal vaginal bleeding   |
| Soreness    | Inability to have intercourse   |                              |

Which type of symptom is the most bothersome (Circle one)?

Vaginal discharge  Itching  Burning  Pain in general  Pain with sex  Dryness  Other: _____

Are your symptoms primarily on the outside lips (vulva), inner lips (labia) or inside (vagina)?

Vulva  Labia  Vagina  A combination

If possible, please mark on the diagram where you feel your symptoms:

What things seem to make your symptoms worse? ____________________________________________

Do any of the things below make your symptoms worse (circle all that apply):

Lying down  Sitting for long periods of time  Exercise  Sex  Tight clothes  Nighttime

What things seem to make your symptoms better? __________________________________________

Are your symptoms related to your period? If so, how?____________________________________

How often do you have symptoms (please circle one)?

Daily  Several times a week  Once a week  Several times a month  Only with sex  other:________

Does the severity of your symptoms change day to day? If so, how?__________________________

Are you currently sexually active?  Yes  No

If not, is this upsetting to you?  Yes  No

Are your sexual partners....  Male  Female  Both/Either

Do your symptoms interfere with your sex life?  Yes  No

Please circle one of the following:  Sex is  Never /  Sometimes /  Always  painful.

Circle any statements that are true for you:

I just don't want to have sex  I don't want to have sex because I am embarrassed by my symptoms

I want to have sex, but can't because of the pain  I don't want to have sex because it is too painful

Sex has never been enjoyable for me  My symptoms cause significant problems in my sexual relationship

I avoid intimacy or relationships because of my symptoms

Relationship Status (circle any that apply)

Single  Dating  Living with Partner  Married  Divorced/Separated  Widowed  Other

Have you ever been in a relationship in which you were threatened, controlled, physical hurt, sexually assaulted or made to feel afraid?  No  Yes

Have you used any of the following products? If so, when, and did it help?

<table>
<thead>
<tr>
<th>Products</th>
<th>When</th>
<th>How many times?</th>
<th>Did it help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the counter yeast cream</td>
<td></td>
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<tr>
<td>Fluconazole (Diflucan)</td>
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<tr>
<td>Mycolog/Lotrisone</td>
<td></td>
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<tr>
<td>Other prescription yeast cream</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Flagyl (pill)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Metrogel</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal clindamycin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clobetasol (Temovate)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocortisone</td>
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<td></td>
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</tr>
<tr>
<td>Amitryptiline/Nortryptiline</td>
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<td></td>
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<tr>
<td>Gabapentin/Lyrica</td>
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<td></td>
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<tr>
<td>Vagifem</td>
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<tr>
<td>Estring</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Estrogen vaginal cream</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Topical gabapentin (compounded)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Topical lidocaine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal valium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other prescription gabapentin (compounded)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical lidocaine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal valium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Have you ever done pelvic floor physical therapy?  Yes – helped  Yes – didn’t help  No
Have you ever had a trigger point injection? Yes – helped  Yes – didn’t help  No
Have you ever been treated with vaginal laser? Yes – helped  Yes – didn’t help  No
Have you ever had a vulvar biopsy?  Yes  No
If yes, when and what did it show?__________________________________________________________

Have you used any of the following to treat your vaginal symptoms? (Circle all that apply)

- Oral probiotics
- Vaginal probiotics
- Vaginal garlic
- Oral garlic
- Douches
- Tea tree oil
- Oral yogurt
- Vaginal yogurt
- Boric acid
- Witch hazel
- Hydrogen peroxide
- Gold Bond powder

GYNECOLOGIC HISTORY

Have you ever been diagnosed with any of the following? (circle all that apply)
- Yeast
- Chlamydia
- Genital Herpes
- PID (pelvic inflammatory disease)
- Bacterial vaginosis
- Gonorrhea
- Genital warts/HPV
- Trichomonas
- Syphilis
- HIV (AIDS)

Have you ever been diagnosed with any of the following? (circle all that apply)
- Uterine fibroids
- Ovarian cysts
- PCOS
- Endometriosis
- Uterine polyps
- Cervical polyps
- Bartholin’s cyst/abscess

Menstrual History:
Are you menopausal?  Yes  No  (if yes, how old were you when you stopped periods?_______)

Menopause: (If you are not menopausal, skip to the next section)
Do you use any hormonal treatments?  No  Yes, __________________________ (what kind)
Do you have any of the following?  Hot flashes  Vaginal dryness  Night sweats

Menstrual periods:
Are your periods regular?  Yes  No, irregular  No, absent because of medication or IUD  No, other
If other, please describe:______________________________________________________________
Do you have any of the following? (circle)  Heavy periods  Painful periods  Bleeding between periods
When was your last period?________________________

What form of birth control, if any, are you using currently? (please circle all that apply)
- Diaphragm/cervical cap
- Oral contraceptive (pills)
- IUD - Copper
- Rhythm method
- Condom/spermicide
- Contraceptive patch
- IUD - hormonal
- Withdrawal
- Depo Provera
- Contraceptive ring
- Vasectomy
- Abstinence
- Tubal Ligation
- Implant (Nexplanon)
- None

Pap Smear History:
Date of last pap:__________________________ Was it normal?  Yes  No  Not sure
Have you ever had an abnormal pap smear?  Yes  No
If so, when?______________________________
How was it managed (circle)?  Repeat Pap  Colposcopy & Biopsy  LEEP  Cone biopsy  Other

OBSTETRIC HISTORY

<table>
<thead>
<tr>
<th></th>
<th>Total pregnancies</th>
<th>Vaginal deliveries</th>
<th>Cesarean deliveries</th>
<th>Miscarriages</th>
<th>Abortions</th>
<th>Living children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are you planning a pregnancy in the next year?  Yes  No

**MEDICAL HISTORY** (Please circle any condition you have now or have had in the past)

<table>
<thead>
<tr>
<th>Asthma or lung problems</th>
<th>Ulcerative colitis</th>
<th>Migraines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lichen planus</td>
<td>Irritable bowel syndrome</td>
<td>Blood clots</td>
</tr>
<tr>
<td>Lichen sclerosus</td>
<td>Crohn’s Disease</td>
<td>Blood transfusion</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Stomach ulcers, reflux, GERD</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Seasonal allergies</td>
<td>Sjogren’s</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Lupus</td>
<td>Interstitial cystitis</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Thyroid disorder</td>
<td>Psoriasis</td>
</tr>
<tr>
<td>Cancer</td>
<td>Liver disease</td>
<td>Eczema</td>
</tr>
<tr>
<td>Chronic fatigue syndrome</td>
<td>Multiple sclerosis</td>
<td>Other:</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Depression</td>
<td></td>
</tr>
</tbody>
</table>

**Surgical History:** (please list all your prior surgeries, hospitalizations and dates)

| Have you had any of these additional symptoms/problems this week? (circle all that apply):
| Leaking urine with cough or sneeze | Abdominal pain | Itchy skin (not on vulva) |
| Leaking urine on the way to bathroom | Rectal bleeding | Eczema |
| Painful urination | Constipation | Mouth Ulcers |
| Difficulty emptying bladder | Diarrhea | Itchy or dry Eyes |
| Up at night frequently to pee | Back or hip pain | Dry mouth |
| Numbness in hands or feet | Joint Pain | Problems Sleeping |
| Burning/tingling in hands or feet | Chest Pain | Trouble Breathing |
| Dizziness | Fevers/Chills | Cough |

**Over the last 2 weeks, how often have you been bothered by the following problems?** (circle) (PHQ-4)

<table>
<thead>
<tr>
<th>1. Feeling Nervous, anxious or on edge</th>
<th>Not at All</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Little interest of pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

OTHER INFORMATION:

Do you work outside the home? Yes No If yes, what is your occupation__________________________

Are you currently using tobacco (smoking, chewing, electronic cigarette/vaping)? No____ Yes ______

How many alcoholic drinks do you have in an average week? (circle) None 0-2 3-6 7-10 >10

Have you used an illegal drug or prescription medication for nonmedical reasons in the last year? No_____Yes____

How often do you exercise? (circle) Never 1-2 times/week 3-5 times/week Daily

If not exercising, why not?______________________________________________________________________________

What questions would you like answered at this visit?

__________________________________________________________________________________________________________

What are you hoping for from this visit?

__________________________________________________________________________________________________________

Thank you very much for taking the time to complete this questionnaire!