Gayle B. Harris, MD

VULVAR PROBLEM QUESTIONNAIRE

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____-_____

Home Phone: (_____)_____-_____ Work Phone: : (_____)_____-_____

Cell Phone: (_____)_____-_____ Age: _____ DOB: _____

Marital Status: □ Married □ Seperated/Divorced □ Widowed □ Single □ Living w/partner
(□ Male or □ Female)

Number of Children: _____

Age(s):_____ _____ _____ _____
_____ _____ _____ _____

Delivery: □ Vaginal _____ □ C-Section _____
# #

Occupation: _____
Are you currently working? □ Yes □ No □ Full time □ Part time

Does your condition affect your occupation? If so, how? _____

_____

REFERRED BY:

Primary Care Physician: _____

PCP Address: _____

PCP Phone #: (_____)_____-_____ PCP Fax #: (_____)_____-_____

Other Specialist: _____

Specialist Address: _____

Specialist Phone #: (_____)_____-_____ Specialist Fax #: (_____)_____-_____

1.) Do you take any medications on a routine basis? □ Yes □ No
If yes, please list:

Medication	Dosage	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2.) Do you have allergies to medications or food? □ Yes □ No
If yes, please list:

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

3.) Are you having menstrual periods? □ Yes □ No

4.) Do you have back pain with your periods? □ Yes □ No

5.) When was your last menstrual period? _____

6.) Are your menstrual periods □ Regular □ Irregular

7.) Do you regularly wear □ Pad □ Tampon

8.) What is your method of birth control? _____

9.) What is your major vulvar/vulvovaginal problem? _____

_____

_____

10.) When did it start? _____

11.) Were there any precipitating factors? □ Yes □ No

If yes, please explain: _____

_____

12.) List the treatments that you have been given either by a physician or over the counter (non-prescription) for this problem. *(This information is not always included in the medical records received from your doctor, please try to be complete.)*

_____

_____

13.) Please describe in your own words, what has been happening to you? What have you done for you problem? Try to make a list of various treatments you may have had, who prescribed them and what the responses were. *(If at all possible, try to get copies of your records from the previous physicians you have seen with lists of medications you have used and comments as to whether they have helped or not.)*

_____

_____

_____

14.) Have you had a vulvar biopsy? □ Yes □ No

15.) What bothers you most about your problem? _____

_____

_____

16.) Have you ever been free of the symptoms at any time? □ Yes □ No

If so, when? _____

17.) What makes your symptoms worse? _____

_____

18.) What makes your symptoms better or gives you relief? _____

_____

19.) How long have you had your symptoms? _____

20.) Are the symptoms you have now worse or better than they were originally? _____

_____

21.) Are your symptoms worse at certain times of the day than others? _____

_____

22.) Are your symptoms worse or better after your menstrual period? _____

23.) Does certain clothing make you uncomfortable? _____

24.) Have you had problems with vaginal discharge? _____

If so, what type of vaginal discharge have you had? _____

25.) Are you having pain, itch or both? _____

26.) Please quantify you average pain or itch with your problem:

Mild Moderate Severe

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

27.) If you are itchy, are you waking up at night scratching? □ Yes □ No

28.) If you are in pain, would you describe it as:

- □ Burning
- □ Pulsating/throbbing
- □ Deep, steady inside ache
- □ Diffuse over the whole vulvar area
- □ Localized to one spot/predominantly on one side

29.) Do your symptoms affecting your sexual activity? _____

30.) Have you had to stop being sexual? _____

31.) Can you participate in comfortable sexual activity? _____

32.) Is your sexual partner aware of your problem? _____

33.) If aware of the problem, is the reaction:

- □ Sympathy
- □ Frustration
- □ Anger
- □ Indifference
- □ Other _____

34.) What do you use for genital washing, lubrication, treatment? _____

35.) How often do you wash this area? _____

36.) Do you shower, tub bathe or shave? _____

37.) List any soaps, douches, powders, sprays, creams, moisturizers or ointments you are using:

_____ _____

_____ _____

_____ _____

38.) Do you wear panty liners? □ Yes □ No

39.) Does you discomfort interfere with you daily routine or planned activities? _____

_____

40.) What do you believe caused your problem? _____

_____

PAST HISTORY LIST

List all prior medical illnesses or injuries: _____

_____

_____

Do you have a prior history of back injuries, slipped disc, sciatica, coccyx (tailbone) or have you ever fallen off a swing or a similar type of injury? _____

_____

_____

Have you seen a chiropractor for back or pelvic problems? □ Yes □ No

Please list any surgeries and year:

Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

Please list any hospitalizations:

_____ _____

_____ _____

_____ _____

FAMILY HISTORY/SOCIAL HISTORY

Do you smoke? □ Yes □ No

Did you used to smoke? □ Yes □ No

FOR YOU MEDICAL HISTORY, PLEASE CHECK ALL THAT APPLY:

□ Allergies	□ Eczema	□ Hay fever
□ Endometriosis	□ Kidney stones	□ Psoriasis
□ Car Accident	□ Hip/leg injury	□ Sexual abuse
□ Physical Abuse	□ Urinary problem	□ Herpes/shingles
□ Low back pain	□ Arthritis	□ Depression
□ Chlamydia	□ Diabetes	□ Thyroid
□ Genital warts	□ Abnormal pap smear	□ General muscle pain
□ Chemical sensitivities	□ Fibromyalgia	□ Migraines
□ Interstitial cystitis	□ Chronic fatigue syndrome	□ Asthma
□ Mental abuse	□ Cancer	□ Bacterial vaginitis
□ Stress	□ Yeast infection	

Is there a family history of allergies, eczema or hay fever? □ Yes □ No

History of sexually transmitted diseases:

□ Gonorrhea □ Syphilis □ HIV/AIDS □ Warts □ Herpes simplex

SEXUAL HISTORY

Ever had sex? □ Yes □ No If yes, number of partners? _____

Are you sexually active with men or women? _____

Method of birth control: □ Oral contraceptives □ Condoms □ Other: _____

_____

History of sexually transmitted infections: □ Yes □ No

If yes, please list: _____

PLEASE FILL OUT IF YOU HAVE VULVA OR VAGINAL PAIN

□ Burning	□ Irritation	□ Soreness	□ Stabbing	□ Aching
□ Stinging	□ Paper cuts	□ Pain	□ Rawness	□ Itching

Do you have pain with intercourse? □ Yes □ No

Do you have pain when nothing is touching the area? □ Yes □ No

Where is your pain?
□ Opening of your vagina
□ On the inner lips of the vagina or vulva
□ On the outer lips of the vagina or vulva near the rectum
□ On the area covered with hair
□ Away from the opening of the vagina

Do you have pain free intervals? □ Yes □ No

What happened when all this began? _____

_____

When you are sexually active, do you have pain with penetration? □ Yes □ No

During intercourse? □ Yes □ No

After intercourse? □ Yes □ No

With all partners? □ Yes □ No

Do you have pain with any of the following?

Insertion of tampon?	□ Yes	□ No	With standing?	□ Yes	□ No
Wearing tight jean?	□ Yes	□ No	With sitting?	□ Yes	□ No
Riding a bicycle or horse?	□ Yes	□ No	While lying down?	□ Yes	□ No
With urination?	□ Yes	□ No			

Are your symptoms worse? □ Before □ After □ Between
□ Or not related to your periods

Do you have any of the following problems?

Constipation	□ Yes	□ No
Diarrhea or bowel changes	□ Yes	□ No
Difficulties with burning or stinging during urination	□ Yes	□ No
Urinary frequency	□ Yes	□ No

The following is a list of medications you may have used. Please circle the comments that apply:

Were you treated for yeast infections?		□ Yes	□ No
If so, did the treatment make it:	worse	better	pain free
Were you treated with cortisone creams or ointments?		□ Yes	□ No
If so, did they make the pain:	worse	better	pain free
Were you treated with estrogen?		□ Yes	□ No
If so, did they make the pain:	worse	better	pain free

Tricyclic medications are used for pain-amitriptyline, desipramine or imipramine.
If used, they make the pain: worse better pain free

Did you use the low-oxalate diet with calcium oxalate?		□ Yes	□ No
If used, they make the pain:	worse	better	pain free
Have you had pelvic floor rehabilitation/biofeedback?		□ Yes	□ No
If so, did they make the pain:	worse	better	pain free

Patient Assessment Questionnaire

For each question below, please circle the answer that best describes how you feel.

The last 2 columns on the right are for your doctor to assess your score. Please do not mark anything in these columns. Be sure to bring this questionnaire with you into the examination room so that you can review your answers with your doctor.

Patient's Name: _____ Date: _____

		0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1	How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2	a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
	b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3	Are you currently sexually active? □ Yes □ No							
4	a. If you are sexually active, do you now or have you ever had pain or symptoms during or after intercourse?	Never	Occasionally	Usually	Always			
	b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5	Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra or perineum) ?	Never	Occasionally	Usually	Always			
6	Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7	a. If you have pain, is it usually…..		Mild	Moderate	Severe			
	b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8	a. If you have urgency, is it usually….		Mild	Moderate	Severe			
	b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
		SYMPTOM SCORE (1, 2a, 4a, 5, 6, 7a, 8a) = SUBTOTAL						
		BOTHER SCORE (2b, 4b, 7b, 8b) = SUBTOTAL						
		TOTAL SCORE (Symptom Score + Bother Score)						