

VULVAR PAIN QUESTIONNAIRE

Please complete this form and give it directly to the doctor at your first appointment, do not send in prior to your appointment.

REFERRING DOCTOR'S NAME _____
ADDRESS _____
CITY / STATE _____

Your Name _____
Today's date _____ Date of Birth _____

Marital Status _____ if not married, are you in a relationship _____
Age _____

MEDICAL HISTORY

Number of pregnancies _____ Number of children (and their ages) _____
Age of 1st menstrual period _____
Last menstrual period (date) _____ Vaginal/Caesarian _____

Have you ever been on Birth Control Pills? NO YES
When? _____
Brand(s) _____

Present method of birth control: _____
Age you first had intercourse: _____ Number of prior sexual partners _____

Has intercourse *always* been painful? NO YES
Gynecology problems, procedures, or surgeries? NO YES (If yes, please give dates)

Hysterectomy If yes, reason _____
Abnormal Pap smear If yes, for dysplasia/cancer treated with
cryo

HPV If yes, high risk
Laser of cervix If yes, for HPV (warts) for dysplasia/cancer
Laser of vulva (CO2 laser) If yes, for HPV (warts) for dysplasia/cancer
Removal of ovaries If yes, reason _____
 Leep/Cone If yes, reason _____
Colposcopy If yes, reason _____

Other (use back of page if necessary, but only after completing entire questionnaire)

Urological problems, procedures, or surgeries? NO YES
If yes, please describe _____

Back problems (injury, slipped disc, sciatica, surgery, other)? NO YES

If yes, please describe _____

Other hospitalizations (besides childbirth or those listed above)? NO YES
If yes, please state year, illness, or surgery:

Other health problems: _____

Are you **currently** taking any of the following tablets or medications? Please give **all** medication names and dosages.

Steroids	NO	YES	
_____	If yes, Oral	<input type="checkbox"/> Topical	
Pain killers	NO	YES	
_____	Antidepressant, Antiseizure,		NO
YES _____	or Antipsychotics		

Hormones (including contraceptive pills)	NO	YES	
_____	Antibiotics		NO
YES _____			

All other pills, medicine, or drugs taken regularly? NO YES If yes, please give names.

Are you allergic to or have you had any bad reactions to any drugs? NO YES
If yes, which ones? What happened?

GENERAL

What is your present work or occupation?

What types of work have you done in the past? _____

Any special hobbies? NO YES If yes, what? _____

Do you do any physical fitness activities? NO YES

If yes, what? How often? _____

Do you smoke tobacco? NO YES If yes, how much each day? _____

Do you drink alcohol? NO YES If yes, how much each week? _____

Do you eat any special foods or stay on a certain diet? NO YES
If yes, what things are included or excluded? _____

PRESENT PROBLEM

In your own words, describe the symptoms (discomfort) you are having. **Be very specific and give as many adjectives as possible.**

When did you first begin having discomfort?

Have you been free of symptoms since your problem began ? NO YES
If yes, when? _____

What seems to make your symptoms worse ?

What can you do to get relief? _____

How are the symptoms you now have related to your INITIAL symptoms?

- same
- less intense discomfort
- more intense discomfort
- less frequent
- more frequent

Are there certain times of the month when your symptoms are more noticeable?

- always the same during the month
- worse just before my menstrual cycle
- worse during my menstrual cycle
- worse just after my menstrual cycle

worse when I ovulate (mid-cycle)

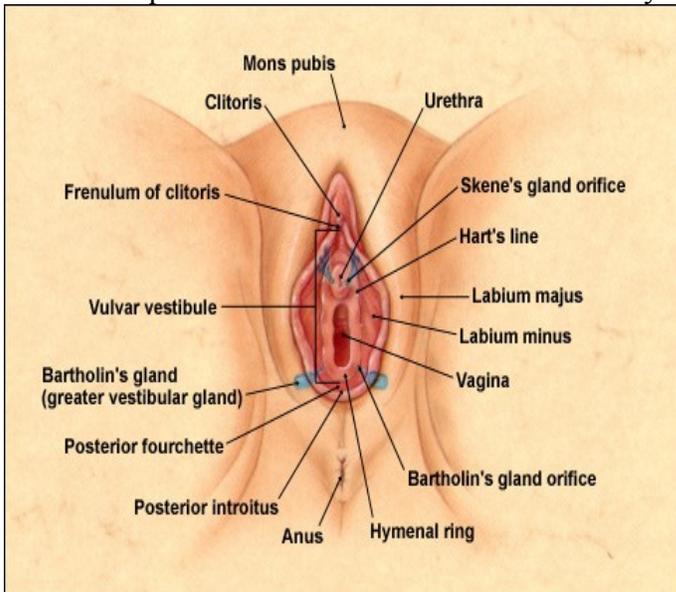
With regard to the urinary tract and bladder, do you any of the following problems?

- have to urinate more than five times in 12 hours
- get up more than twice at night to urinate
- frequent urinary tract infections
- difficulty voiding
- bladder pain which improves after voiding
- urinary urgency
- urinary hesitancy
- burning during urination
- incomplete emptying

During my menstrual period:

- I use a sanitary pad exclusively
- I use tampons exclusively
- I use tampons and/or pads depending on the flow
- Sanitary pads make my discomfort worse
- Tampons make my discomfort worse
- I do not menstruate

Mark the squares which best show the location of your symptoms:



- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> pubic area | <input type="checkbox"/> clitoris | <input type="checkbox"/> vulva (outside lips) |
| <input type="checkbox"/> urethra (bladder opening) | <input type="checkbox"/> labia (| <input type="checkbox"/> vagina (inside) |
| <input type="checkbox"/> perineum | <input type="checkbox"/> rectal area | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> vestibule | <input type="checkbox"/> clitoris | |

My feelings of discomfort can best be described as:

- diffuse (over the whole vulvar area)
- localized (in one or more specific small spots)
- pulsating (throbbing)

- deep, steady ache
- predominantly on one side
- itching burning raw tearing ripping
- cutting dry other (describe) _____

Are bouts of discomfort essentially alike? NO YES

If no, how do they differ?

- kind of discomfort (e.g. constant aching vs. throbbing)
- location of pain
- associated symptoms
- intensity of discomfort
- other (describe)

On a scale from 0 to 100, where 0 represents no discomfort at all and 100 represents the most pain you could possibly stand, what value would you assign to:

- Your worst symptoms _____
- Your usual symptoms _____
- Your current symptoms _____

My discomfort usually causes:

- NO interference with daily routine or planned activities
- SOME interference with daily routine or planned activities
- an interruption in daily routine or planned activities
- confinement to bed
- the pursuit of immediate medical attention

My symptoms:

- do not affect sexual intercourse for me
- sometimes prevent me from sexual intercourse
- completely prevent sexual intercourse
- cause discomfort, but do not prevent sexual intercourse
- don't know – I am not sexually active (skip the next two questions)

If I try to have intercourse, my discomfort is: (indicate as many as apply)

- not a problem
- worse with certain positions
- mostly at the opening of the vagina (entry is painful)
- painful at entry, then intercourse is tolerable
- mostly irritated afterward for an hour or so
- mostly irritated afterward for a day or so

With regard to sexual activity and foreplay:

- I am easily aroused, and have good natural vaginal lubrication
- I get aroused, but vaginal dryness is often a problem
- sexual arousal makes my vaginal symptoms worse

arousal feels good, but intercourse is painful
I have a hard time getting sexually aroused

With regard to sexual activity IN THE PAST: (indicate as many as apply)

- I used to enjoy sexual intercourse
- intercourse has always been somewhat uncomfortable
- I have been forced to have intercourse against my will (one or more times)
- I had unpleasant sexual experience(s) in my childhood
- I think my past experiences may have caused some of the problems I have now
- I think my past sexual activity would be considered pretty normal
- other (comment) _____

Is your partner aware of your problem? NO YES

Is yes, what is the reaction? _____

Have you been to another physician for this problem? NO YES

If yes, please indicate his/her specialty and please list all:

- Family practitioner
- Internist (general medicine)
- Gynecologist (list all)

- Urologist if more than one, how many? _____
- Dermatologist if more than one, how many? _____
- other (indicate) _____

Have you been told what condition is causing your symptoms? What have you been told?

Have your doctors prescribed or recommended any medications for your problem?

NO YES

If yes, please give the names of ALL substances that you have used.

(include vaginal preparations, skin creams, pills, etc.) THIS IS VERY IMPORTANT

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

On the list, CIRCLE THE BEST treatment and UNDERLINE THE WORST treatments

What do you believe caused your problem?

Thank you for completing this questionnaire. Your doctor will review the answers and may ask additional questions during your evaluation. The confidential questionnaire will become a part of your medical record. This data may be tabulated (without your name) in the course of research studies to learn which factors seem most important in evaluating other patients with these similar problems. In addition, you may have photographs taken of your genitals taken during the evaluation. You may refuse consent to have these photographs taken.

Sign _____ Date _____