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 □ 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)

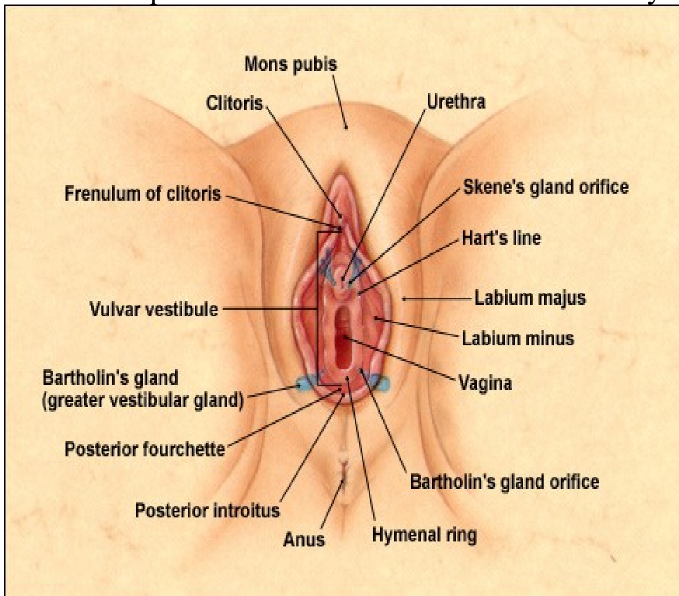
With regard to the urinary tract and bladder, do you any of the following problems?

- ☐ 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:



pubic area	clitoris	vulva (outside lips)
urethra (bladder opening)	labia (	vagina (inside)
perineum	rectal area	☐ other ________________
☐ vestibule	☐ 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__________________