This section is for our patients with chronic vulva or vaginal pain, burning or itching who are being seen in our Vulva Disorders Clinic.

VULVAR PAIN HISTORY

Do you have vulvar pain?

When did you first experience this vulvar pain? Month____________________
Year ____________________

Do you recall any specific incident that occurred when your pain first began? ☐ Yes ☐ No

If yes, please indicate event: (ex: since first intercourse, since first tampon insertion, after recurrent yeast infection, after childbirth, etc)

☐ Since first vaginal intercourse
☐ Since first tampon insertion
☐ After yeast infection (or other vaginal infection)
☐ After childbirth
☐ After an injury (describe:____)
☐ Other: ____

Are your symptoms? (check all that apply):

☐ Intermittent (every now and then)
☐ Continuous (all day long)
☐ Every day
☐ Only with intercourse

Rate the **INTENSITY** of your pain (mark the line with an X)

____

0 (0= none) — 10 (10=worst imaginable)

Rate the **UNPLEASANTNESS** of your pain (mark the line with an X)

____

0 (0= none) — 10 (10=worst imaginable)

Does the pain **radiate** (move to other parts of your body)? ☐ Yes ☐ No

Does the pain ever **wake you up** from your sleep? ☐ Yes ☐ No

VULVAR SYMPTOM HISTORY

Are your vulvar symptoms brought on or made worse by any of the following? **Check all that apply.**

- ☐ menstruation
- ☐ exercise
- ☐ bicycle riding
- ☐ tampons
- ☐ partner touch
- ☐ fear
- ☐ masturbation
- ☐ walking
- ☐ cold
- ☐ hot tub
- ☐ heat
- ☐ sweating
- ☐ urinating
- ☐ menstrual pads
- ☐ stress
- ☐ sexual intercourse
- ☐ long periods of driving
- ☐ tight clothing
- ☐ Other, please specify:____

Are your vulvar symptoms relieved by any of the following? **Please check all that apply.**

- ☐ heat
- ☐ sitz bath
- ☐ shower
- ☐ alcohol
- ☐ exercise
- ☐ hot tub
- ☐ cold/ice
- ☐ standing
- ☐ sitting
- ☐ lying down
- ☐ tub bath
- ☐ loose clothing
- ☐ douching
- ☐ relaxation
- ☐ no underwear
- ☐ being distracted by another activity
- ☐ oral medication, please specify:________________________________
- ☐ topical medication or cream, please specify:_________________________
- ☐ Other, please specify:____

What is your most comfortable position?

- ☐ sitting
- ☐ lying down
- ☐ other: ___________________________

Do you have any of these associated symptoms?	Not at all	A little bit	Some-what	A great deal	A very great deal
Vulvar itching	☐	☐	☐	☐	☐
Vulvar scratching	☐	☐	☐	☐	☐
Vaginal discharge	☐	☐	☐	☐	☐
Vulvar sores, ulcers, fissures, cuts or tears	☐	☐	☐	☐	☐
Burning with urination	☐	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐	☐
Pelvic pain	☐	☐	☐	☐	☐
Pelvic pressure	☐	☐	☐	☐	☐
Rectal fissures	☐	☐	☐	☐	☐

PRIOR EVALUATION FOR VULVAR SYMPTOMS:

Vulvar biopsy?	☐ Yes ☐ No	If yes, date: ______ Results: ______
Vaginal or vulvar cultures?	☐ Yes ☐ No	If yes, date: ______ Results: ______
Vulvoscopy/ Colposcopy (maginification of vulva with application of vinegar solution)?	☐ Yes ☐ No	If yes, date: ______ Results: ______

PRIOR SURGICAL AND MEDICAL TREATMENTS for Vulvar symptoms:

Have you had any of these procedures for the treatment of your vulvar symptoms?	**YES**	**NO**	**IF YES, HOW HELPFUL ?** ***Check one box***				
			NOT at all	A little bit	Some-what	A great deal	A very great deal
Laser treatment Date:______ Hospital: ______	☐	☐	☐	☐	☐	☐	☐
Surgery Type of surgery:______ Date: ______ Hospital:______	☐	☐	☐	☐	☐	☐	☐
Injections Date:______ Type: ______	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

PLEASE LIST ALL MEDICATIONS (ORAL MEDICATIONS AND CREAMS) THAT YOU HAVE USED FOR YOUR VULVAR SYMPTOMS.

MEDICATION & DOSE	CHECK BOX IF STILL USING THIS MED	**HOW HELPFUL ?** *Check one box*				
		NOT at all	A little bit	Some-what	A great deal	A very great deal
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

VULVAR HYGIENE

Do you use vaginal douches? ☐ Yes ☐ No

Do you wash the vulva with soap and if so what brand? ______________________________

Do you wear cotton panties or cotton crouch panties?

Perineal hygiene: (**check all that apply**)

Shower (# per week______)

Bath (# per week______)

Tampons______

Menstrual pads ______

Other Cleansing Products (describe): ____

Below is a list of gynecological problems. Please indicate those problems for which you have had symptoms or been diagnosed.

- ☐ Yeast infections
- ☐ Bacterial vaginosis
- ☐ Chlamydia
- ☐ Herpes
- ☐ Trichomonas
- ☐ Syphilis
- ☐ Frequent urinary tract infection
- ☐ Chronic vaginal discharge
- ☐ Pelvic inflammatory disease
- ☐ HPV (human papilloma virus, genital warts)
- ☐ Cervical dysplasia (**abnormal pap smear**)
- ☐ AIDS / HIV

If you have had a yeast infection, please answer the following:

_______age at first yeast infection _______No. of yeast infections/year

_______most recent yeast infection

Treatments for yeast (mark all that apply): #creams # suppositories # oral medications

CONTRACEPTION: ***Please mark all boxes that apply***

Method	Currently Use	Used in the past	Duration of use (years)
Birth control pills	☐	☐	
IUD	☐	☐	
Tubal Ligation	☐	☐	
Essure	☐	☐	
Condoms	☐	☐	
Rhythm method	☐	☐	
Abstinence	☐	☐	
Other:	☐	☐	

If you have ever used a hormonal contraceptive (i.e. birth control pills, patch, injections) anytime in your past, please answer the following 2 questions:

1. When you **first** started using hormonal contraceptives, what was the main reason for it? Many people have multiple reasons for starting hormonal contraceptives. *(Please mark the **main** reason you first were started on hormonal treatment by a health care provider)*	❑ Gynecologic problems ❑ Contraception ❑ Headaches ❑ Acne treatment ❑ Don't remember
2. If you first started using hormonal contraceptives for a GYNECOLOGIC problem, *Please mark all reasons you started taking or using hormonal contraceptives*	❑ Did not use for a gynecologic reason ❑ Painful periods ❑ Irregular or heavy periods ❑ Ovarian cysts ❑ Pelvic pain and/or endometriosis ❑ Premenstrual syndrome ❑ Other reasons: ___________________________

PLANS FOR PREGNANCY:	Yes	No	Uncertain	Not applicable
Do you plan to become pregnant in the future?	☐	☐	☐	☐
Do you and your partner agree regarding future pregnancies?	☐	☐	☐	☐
Do you fear becoming pregnant?	☐	☐	☐	☐
Do you feel your choice of birth control is reliable?	☐	☐	☐	☐
Had you had any **treatment for infertility**?	☐	☐		

If you have had treatment for infertility, please specify:
What?____
When?____

MENSTRUAL HISTORY:

Do you have menstrual periods? ☐ Yes ☐ No

If you do not have menstrual periods, please indicate the reason:

☐ menopause (age of menopause:______________years old)
☐ surgical removal of both ovaries
☐ hormonal medication (specify:_________________________________)
☐ Don't know

If you still have your periods, how many days are there between your menstrual periods? • (from the 1st day of one period to the 1st day of the next period) • if your periods are irregular, please give a range (ex: 26-35 days between periods)	__________days
How many days does your period typically last?	__________days

Do you have pain/cramps with your periods?

☐ none
☐ mild
☐ moderate
☐ severe

Do you take medications for pain/cramps with your periods? **How often?**

☐ none
☐ Ibuprofen, Tylenol, Aleve, Naprosyn ☐ Never ☐ Sometimes ☐ Every period
☐ Prescription pain medications (ex: Vicodin, Darvocet, Percocet) ☐ Never ☐ Sometimes ☐ Every period
☐ Other: _____________________________ ☐ Never ☐ Sometimes ☐ Every period

CURRENT MEDICAL STATUS Please indicate those problems for which you have had symptoms or been diagnosed.

Medical Problem	√ = yes	Medical Problem	√ = yes
High blood pressure		Ulcerative Colitis	
Angina or Chest pain		Crohn's Disease	
Irregular heart beat or Palpitations		Irritable Bowel syndrome	
Asthma		Chronic constipation	
Chronic Headaches		Rectal Fissures	
Thyroid disease (Specify:____________________)		Stomach Ulcer	
Kidney problems (Specify:____________________)		Reflux (heart burn)	
Liver problems (Specify:____________________)		Overactive Bladder	
Cancer (Specify:__________________________)		Leak urine with sneezing	
Other:		Interstitial Cystitis	
Other:		Fibromyalgia	
Other:		TMJ	
Other:			

Have you ever been diagnosed or treated for any of these mental health problems?

Condition	Yes	No	Month & Year of diagnosis	Treatment:			Year of treatment
				Medication	counseling	hospitalization	
Depression	☐	☐		☐	☐	☐	
Anxiety	☐	☐		☐	☐	☐	
Bipolar Disorder	☐	☐		☐	☐	☐	
Schizophrenia				☐	☐	☐	
Other:							

Please list all medication you currently take: Include any over-the-counter and herbal medicine

Medication	Dose	Frequency

List all of your allergies, including allergies to medications:

____

____

____

List all previous surgeries along with their dates (include D&C's, tonsillectomies, appendectomies, etc.):

Surgery	Date	Comment

FAMILY HISTORY: Do you have any family members with Vulvar Problems or other medical problems? If yes, please list the relative and their problem. Be sure to include any history of cancer (including type of cancer).

Family Member	Vulvar or Medical Problem

Has anyone in your family had a history of depression or psychiatric problems? ☐Yes ☐No

If yes, please specify:______________________________

HEALTH HABITS:

	Yes	No	Not now, but yes in the past	If YES:
Smoke cigarettes	☐	☐	☐	Packs per day: years:
Drink alcohol	☐	☐	☐	Drinks per week: years:
Smoke marijuana	☐	☐	☐	# per week:
Exercise	☐	☐	☐	Hours per week:

Is there any history of alcohol or drug abuse in you or your family members? (please check all that apply)

☐Myself ☐Sibling(s) ☐Partner ☐ Parent(s) ☐Son or daughter

Current relationship status:

☐ Married	☐ Widowed (When:________________)
☐ Cohabitating	☐ Separated or divorced (When:___________)
☐ Single	☐ In a stable relationship (How long:________)

How would you describe your sexuality?

☐Heterosexual (sex with men)
☐Bisexual (sex with men and women)
☐Lesbian (sex with women)

Please mark any that apply to your **current** sexual activity:	☐ None ☐ vaginal sex ☐ Masturbation ☐ Oral sex ☐ Anal sex ☐ Mutual stimulation by partner ☐ Instruments for orgasm (i.e. vibrator, sex toys)
Quality of **current** sexual activity:	☐ Generally very satisfying ☐ Sometimes satisfactory ☐ Rarely satisfactory ☐ Never satisfactory
Quality of sexual activity **prior to symptoms**:	☐ Generally very satisfying ☐ Sometimes satisfactory ☐ Rarely satisfactory ☐ Never satisfactory
Frequency of sexual activity:	☐ 2 or more times per week ☐ once per week ☐ 2-3 times per month ☐ once per month ☐ less than once per month ☐ rarely ☐ never sexually active
Are you orgasmic?	☐ Always ☐ Sometimes ☐ Very Infrequently ☐ Never
If yes, by:	Partner stimulation ☐ Yes ☐ No Masturbation ☐ Yes ☐ No vaginal intercourse ☐ Yes ☐ No anal intercourse sex ☐ Yes ☐ No oral sex ☐ Yes ☐ No

Are you currently involved in a relationship outside of your primary relationship?

☐ Yes ☐ No If yes, duration:______________________________

Recent change or divorce regarding partner? ☐ Yes ☐ No

if yes, what change? ____________________________________

Please circle the number that most closely applies to you for the following questions.

I am **interested** in sex:	**1** **2** **3** **4** **5** (No interest) (High interest)
How do feel about yourself as a **sexual person**?	**1** **2** **3** **4** **5** (Very negative) (Very positive)
Vaginal sexual activity is important to me:	**1** **2** **3** **4** **5** (Not important) (Very important)

Do you use **lubricants** with vaginal intercourse? #Always #Sometimes #Never

If yes, what type? ______________________________

Does your partner have sexual difficulty? ☐Yes ☐No ☐Uncertain

If yes, please check all that apply:

- ☐ erection difficulties
- ☐ rapid ejaculation
- ☐ fear of hurting
- ☐ low sexual desire
- ☐ Other: ____________________

Does sexual activity bring up negative thoughts and remind you of past trauma? ☐Yes ☐No ☐Uncertain

If yes, what concerns do you have? (please describe)

____
____
____
____
____

<u>Review of Symptoms</u>: Please mark any symptoms that you have experienced in the last 3 months.

	√ = yes		√ = yes
General		**Gastrointestinal**	
Chronic fatigue		Nausea or vomiting	
Fevers		Poor appetite	
Difficulty falling or staying asleep		Abdominal bloating/fullness	
Unintentional weight loss		Heartburn	
Unintentional weight gain		Constipation	
Skin		Diarrhea	
Rash		Blood in stools	
Itching		Pain with bowel movements	
Pigmented or colored mole		**Urinary**	
Head and Neck		Urinary frequency	
Itchy eyes		Urgency	
Sore throat		Urine leaking	
Mouth sores or ulcers		Pain with urination	
Bleeding gums		Blood in urine	
Heart		Incomplete bladder emptying	
Chest pain		Night time urination (>2 /night)	
Irregular heart beat		**Musculoskeletal**	
Ankle/foot swelling		Muscle or joint pain	
Lungs		Body aches or stiffness	
Shortness of breath		Leg pain	
Chronic cough		Back pain	
Wheezing		**Endocrine**	
Neurologic		Excess hair growth	
Headaches		Nipple discharge	
Dizziness		Hot flashes	
Memory loss			
Low attention			

PAIN COGNITIONS SCALE (PCS)

Instructions. *We are interested in looking at the relationship between thoughts and pain. Please indicate the degree to which you have experienced each of the following thoughts or feelings when experiencing pain by indicating the number under each statement.*

WHEN I FEEL PAIN….	**Not at all**				**All the time**
1. I worry all the time about whether the pain will end.	0	1	2	3	4
2. I feel I can't go on.	0	1	2	3	4
3. It's terrible and I think it's never going to get any better.	0	1	2	3	4
4. It's awful and I feel that it overwhelms me.	0	1	2	3	4
5. I feel I can't stand it anymore.	0	1	2	3	4
6. I become afraid that the pain may get worse.	0	1	2	3	4
7. I think of other painful experiences.	0	1	2	3	4
8. I anxiously want the pain to go away.	0	1	2	3	4
9. I can't seem to keep it out of my mind.	0	1	2	3	4
10. I keep thinking about how much it hurts.	0	1	2	3	4
11. I keep thinking about how badly I want the pain to stop.	0	1	2	3	4
12. There is nothing I can do to reduce the intensity of the pain.	0	1	2	3	4
13. I wonder whether something serious may happen.	0	1	2	3	4

Thank you for completing this form.