Vulvovaginal Disorders:
An algorithm for basic adult diagnosis and treatment

WELCOME TO THE VULVOVAGINAL SPECIALTY SERVICE

THE QUESTIONNAIRE:

Your responses to the following INITIAL VISIT QUESTIONNAIRE will help us to understand your experience. Please take your time and try to answer our questions as best you can. Please send the form back to us in the envelope provided; it is especially helpful for us to have this before your visit.

YOUR MEDICAL RECORDS:

Please try to get your medical records to us before your appointment if your primary providers are **outside of our system**. You may need to call your providers a few times, until this is completed. We have included a medical release form that your providers' offices may require and important contact information for our office. If your providers are in our system, and other visits about this problem have been with them, we do not need additional records.

ABOUT YOUR MEDICATIONS, BEFORE YOUR INITIAL VISIT WITH US:

1) ***DO NOT STOP*** YOUR ORAL MEDICATIONS: Do not stop taking any oral medications, except for antifungal medications, like Diflucan (fluconazole). Your last dose of fluconazole should be at least 2 weeks before your visit.

2) ***DO STOP*** using any topical creams/ointments or oils (including over the counter creams and prescription medications, like topical steroids) on the vulva at least 2 weeks before your appointment. **YOU MAY use topical Vaseline** until 48 before your appointment. If you feel that you cannot stop your creams or ointments, please call our office and discuss this with a nurse.

3) ***DO NOT STOP*** using vaginal estrogen, including Vagifem tablets, Estrace (estradiol) cream, or Premarin Cream, but please ***do not insert it*** within 48 hours of your appointment. If you use the Estring, leave it in place.

You should put NOTHING in the vagina, for 48 hours before your appointment.
That is, no intercourse, creams, lubricants, or douches.

PLEASE ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT. WHEN YOU ARRIVE AT OUR OFFICE:

- Please check in at the desk in the main lobby AND with the secretaries in the Women's Health department.

– Your initial appointment is scheduled for one hour, but could be as much as 2 hours. Follow up visits are usually 30 minutes.

VULVOVAGINAL SYMPTOMS/CONCERNS INITIAL VISIT QUESTIONNAIRE

Date_____Name_____Nickname_____Age_____

Who referred you to us? (Please include address.) _____

_____

Occupation_____

Are you in a relationship? (please circle) Married, single, single and in a relationship,

living with partner, separated, divorced, widowed, dating, not in a relationship

How long have you been in your current relationship? _____ Male/Female/Both

How many pregnancies have you had? ____ How many children do you have? _____

How many vaginal deliveries? _____ C-sections? _____

In a few words, please tell us your primary problem:_____

_____

Please tell us about your symptoms. For example, when did symptoms first occur? Do you know what caused them? Do you have itching, burning, irritation, pain, etc…? Are symptoms present all the time, some of the time? How severe are your symptoms? Are you sexually active? If yes, do you have pain with penetration? Do you have concerns about sexual functioning? What else?

What makes your symptoms worse?

What makes your symptoms better?

What have you tried to improve your symptoms? (please include medications prescribed as well as lifestyle changes, such as “wearing no underwear” etc…)

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Please tell us the brands of products that you use:

Bath Soap:_____ Detergent:_____

Fabric Softener:_____ Bleach:_____

Sanitary Pads:_____ Tampons:_____

Panty liner: _____ Douche:_____

Wipes:_____ Other:_____

Do you use daily pantyliners or other protection in your underwear?_____

Your gynecologic history and/or problems:

Do you have **regular periods**? _____ If not, why?_____

What type of **birth control** do you use? _____

Have you had any of the following (please circle): ovarian cyst, PCOS, fibroids, endometriosis, pelvic surgery, DES exposure (born before 1974), perimenopause, menopause,
other_____

Have you had an abnormal Pap? _____ When?_____ What treatments have you had for abnormal Pap? _____What was the date of your last Pap? _____

Vulvovaginal disorders (please circle): yeast, bacterial vaginosis, herpes, chlamydia, gonorrhea, syphilis, genital warts, molluscum, lichen planus, lichen sclerosus, trichomonas, Bartholin's cyst, other_____

Have you ever had a vulvar biopsy? _____

Do you have any history of genital injury or trauma? _____

Do you have any history of sexual abuse/assault? _____

Do you problems in any of the following of the following areas? Please circle.

Urinary: pain with urination, frequent urination, need to go urgently, up at night frequently, interstitial cystitis, urinary leakage, frequent bladder or kidney infections, other_____

_____

Gastrointestinal: constipation, diarrhea, GERD/reflux, irritable bowel syndrome, abdominal pain, rectal fissures, hemorrhoids, rectal bleeding, stomach ulcers, other_____

_____

Musculoskeletal: back injury, chronic back pain, herniated disc, sciatica, back surgery, other:

_____

Dermatologic: problems in your mouth, itching of the skin, scaling, dermatitis, eczema, psoriasis, shingles, other:

_____

Have you had any problems with the following (please circle:) depression, anxiety, high stress, general poor health, lack of emotional support, dissatisfaction with life, difficult relationship, inadequate sleep, distress about vulvar condition, other: _____

_____

CURRENT MEDICATIONS

ALLERGIES

MEDICAL HISTORY

Please check if you have now, or have had in the past, any of the following:

Condition	Have currently	Had in the past	If yes, please explain
Cancer			
Autoimmune condition			
Vit D Deficiency			
Problems with your eyes, ears, nose, throat, mouth			
Heart Disease			
High Cholesterol			
Hypertension			
Breast Disease			
Asthma or lung problems			
Ulcerative Colitis or Crohn Disease			
Liver Disease			
Kidney Disease			
Thyroid Disease			
Diabetes			
Fibromyalgia			
Headaches			
Depression or Anxiety			
Other (please elaborate			

Have you had any surgeries? Please list them with dates.

Family history (please circle): vulvovaginal disorders, autoimmune diseases, thyroid, rheumatoid arthritis, Crohn disease, diabetes, irritable bowel, other_____

How many cigarettes do you smoke a week? _____

How many alcoholic beverages do you have in a week? _____

What recreational drugs do you use? _____

What regular exercise do you do? _____

Thank you very much for taking the time to complete this questionnaire! Use the space below to add anything else you want to tell us.