

## VULVODYNIA QUESTIONNAIRE

Please complete this form and give it directly to the doctor.

REFERRING DOCTOR'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

Today's date \_\_\_\_\_

NAME \_\_\_\_\_ City, State \_\_\_\_\_

Age, Date of birth \_\_\_\_\_ Marital status \_\_\_\_\_

### MEDICAL HISTORY

Number of pregnancies \_\_\_\_\_ Number of children (age of youngest) \_\_\_\_\_

Last menstrual period (date) \_\_\_\_\_

Methods of birth control used in past (give dates) \_\_\_\_\_

Present method of birth control \_\_\_\_\_

Gynecology problems, procedures, or surgeries?  NO  YES (If yes, please give dates)

Hysterectomy If yes, reason \_\_\_\_\_

Abnormal Pap smear If yes,  once only  treated with cryo

Laser of cervix If yes,  for HPV (warts)  for dysplasia or cancer

Laser of vulva (CO<sub>2</sub> laser)  for HPV (warts)  for dysplasia or cancer

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: \_\_\_\_\_

Do you take any of the following tablets or medicines? Please give medication names.

Steroids (cortisone)  NO  YES \_\_\_\_\_

Aspirin or pain killers  NO  YES \_\_\_\_\_

Sedatives or tranquilizers  NO  YES \_\_\_\_\_

Laxatives (for constipation)  NO  YES \_\_\_\_\_

Hormones (including contraceptive pill)  NO  YES \_\_\_\_\_

Antibiotics  NO  YES \_\_\_\_\_

Other pills, medicine, or drugs taken regularly?  NO  YES If yes, please give exact names:

Are you allergic to or have you had any bad reactions to any drugs?  NO  YES

If yes, which ones? What happened?

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SKIN

Does your skin react against or are you allergic to any other substances?  
(i.e. Elastoplast, tape, metal, make-up, or jewelry)  NO  YES If yes, what?

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Indicate your skin coloring and type:	Natural hair color	Eye color
<input type="checkbox"/> very fair (always burn, never tan)	<input type="checkbox"/> Blonde	<input type="checkbox"/> Blue
<input type="checkbox"/> fair (usually burn, tan with difficulty)	<input type="checkbox"/> Red	<input type="checkbox"/> Green
<input type="checkbox"/> average (sometimes burn, tan average)	<input type="checkbox"/> Brown	<input type="checkbox"/> Hazel
<input type="checkbox"/> dark (rarely burn, tan easily)	<input type="checkbox"/> Black	<input type="checkbox"/> Brown
<input type="checkbox"/> Black	<input type="checkbox"/> Grey	<input type="checkbox"/> Black

Would you describe your skin as "sensitive?"  NO  YES If yes, why?

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Do you see a dermatologist regularly?  NO  YES If yes, what is your treatment?

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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 \_\_\_\_\_

Drink sugar-free sodas?  NO  YES If yes, how many each day \_\_\_\_\_

Use sugar substitutes  NO  YES If yes, what % of the time \_\_\_\_\_

Do you eat any special foods or stay on a certain diet?  NO  YES

If yes, what things are included or excluded? \_\_\_\_\_

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Do you regularly take any food supplements or vitamins?  NO  YES

If yes, what? \_\_\_\_\_

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PRESENT PROBLEM

In your own words, describe the symptoms (discomfort) you are having

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What bothers you the most about your problem? \_\_\_\_\_

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Have you been free of symptoms at any time?  NO  YES

If yes, when? \_\_\_\_\_

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What seems to make it worse? \_\_\_\_\_

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What can you do to get relief? \_\_\_\_\_

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When did you first begin having discomfort?

- less than 6 months ago
- 6 months to 1 year ago
- 1 to 3 years ago
- 5 to 10 years ago
- more than 10 years ago

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 day when your symptoms are more noticeable?

(indicate as many as apply)

- always the same throughout the day
- morning
- evening
- night (bedtime)
- with urination

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 after my menstrual cycle
- worse when I ovulate (mid-cycle)

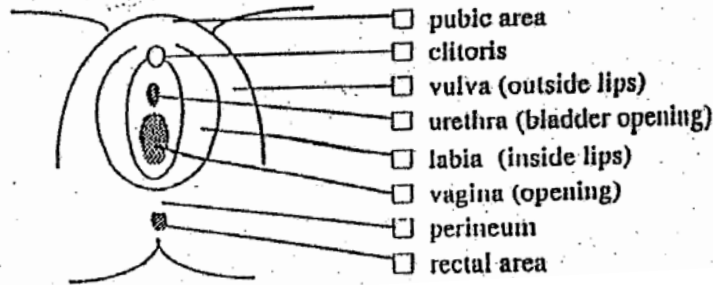
With regard to the urinary tract and bladder, do you have any of the following problems?

- have to urinate more than 5 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

During my menstrual period:

- I use a sanitary pad exclusively
- I use tampons exclusively
- I use tampons and/or pads depending on 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:



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
- other (describe) \_\_\_\_\_

Are bouts of discomfort essentially alike?  NO  YES

If no, how do they differ?

- kind of discomfort (eg constant aching vs throbbing)
- location of pain
- associated symptoms
- intensity of discomfort
- other (describe) \_\_\_\_\_

The statement which describes the discomfort which I most often have:

- slight, I notice only when I think about it
- slight, I can ignore it by not thinking about it
- moderate, I always know it's there but I can still perform most tasks
- severe, it allows me to perform only tasks which require little concentration
- severe, makes it impossible for me to do anything but seek medical attention

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 \_\_\_\_\_

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
- sometimes prevent 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 experience(s) may have caused some of the problems I have now
- I think my past sexual activity would be considered pretty normal
- other (comment) \_\_\_\_\_

When/if my symptoms prevent sexual intercourse, my partner and I:

- avoid sexual intimacy altogether
- are physically close, but avoid sexual arousal
- concentrate on my partner's satisfaction
- have relations as usual

Have you used lubricants during intercourse?       NO    YES

If yes, please give name(s). Any problems?

Is your partner aware of your problem?       NO    YES

If yes, what is the reaction?

Indicate the effect each of the following has on your discomfort:

	RELIEF	NO CHANGE	WORSENS
Heat (like a warm bath)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold (like a cool compress)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friction (rubbing or scratching)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other significant activity (describe)			
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

If yes, please indicate his/her specialty:

- Family practitioner
- Internist (general medicine)
- Gynecologist (if more than one, how many? \_\_\_\_\_)
- Urologist (if more than one, how many? \_\_\_\_\_)
- Dermatologist (if more than one, how many? \_\_\_\_\_)
- other (indicate) \_\_\_\_\_

Have you been treated for any of the following conditions in relation to your present problem?

- Yeast infections
- Urinary tract infections
- Herpes
- Venereal warts (condylomata, HPV)
- Lichen sclerosus
- Interstitial cystitis
- Vaginitis
- Atrophic vaginitis
- other (indicate what kind, or put "DK" if you don't know)