Whole Health Associates – Vulvovaginal Consult Questionnaire

To better understand your vulvar problems, we ask that you please spend some time to complete this form

Patient Name: _____ DOB: _____Age:_____

Email address:_____

Is it okay to contact you via email?_____

Who referred you to Whole Health Associates?_____

Would you like a summary of your visit sent to any other providers? If so, please list below.

_____

Are you currently taking any medications? If so, please list the medication and condition it was prescribed for.

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

Do you have any allergies to any medications or foods?_____

_____

_____

_____

Has your vulvar or vaginal condition ever been given a diagnosis?_____

_____

Please describe your symptoms_____ _

_____

_____

What bothers you the most about your problem?_____

_____

_____

Are you having pain, itch or both?_____

On a scale of 1 (mild symptoms) to 10 (severe symptoms), could you rate your problem?

___1___2___3___4___5___6___7___8___9___10

If you are itchy, are you waking up at night to scratch?_____

If you are in pain, please check below how you describe it:

_____Burning, stinging, or rawness

_____Stabbing or knife-like

_____Paper cuts or splitting

_____Pulsating or throbbing

_____Deep or steady ache inside

_____Diffuse or present over the whole vulvar area

_____Localized to one specific spot or on one specific side of vulva

How long have your symptoms been present?_____

Was there an incident that happened that started your symptoms, such as a vaginal infection, childbirth or surgery?_____

_____

Have you ever been free of symptoms at any time since this problem began?_____

_____

_____

Is this now a constant problem?_____

If you have pain, does touching the area make your pain worse?_____

Is your pain only present if touched?_____

Does this problem affect your work or school? If so, how?_____

_____

_____

How do the symptoms you have now compare with your initial symptoms?

_____Same

_____Less intense or frequent

_____More intense or frequent

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

_____No, they are always the same

_____Yes, in the morning

_____Yes, in the afternoon

_____Yes, in the evening

_____Yes, in the middle of the night

Have you noticed anything in particular that makes your problem worse? If so, please describe._____

_____

_____

Are you sexually active?_____

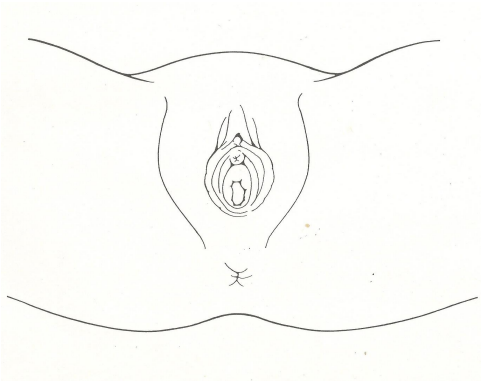
If so, do you have pain with intercourse or other sexual activities?_____

If so, is the pain worse during or after intercourse?_____

How has this condition affected your sexual life?_____

_____

Could you mark or shade in this picture below where your pain or itch is?



Is there anywhere else in your body that you experience pain? If so, please describe._____

_____

Are you currently on birth control or hormone therapy for menopause?_____

_____

If you are menopausal, what age did it begin?_____

Was your menopause natural or following the removal of your ovaries?_____

Have you ever been pregnant? If so, please answer the questions below.

Number of previous pregnancies _____

Date of last pregnancy _____

Abortions/miscarriages (number) _____

Have you breastfed a child in the past 8 months? _____

Are there any medications that you have used in the past for this problem (prescription or non-prescription)? If so, please list including vitamins.

1. _____
2. _____
3. _____
4. _____
5. _____

Did you find any of these treatments helpful or harmful? If so, please explain._____

_____

_____

_____

Does your menstrual cycle affect your symptoms? If so, how?_____

_____

_____

Does urination affect your symptoms? If so, does your skin burn when the urine hits your skin?_____

Does certain clothing affect your symptoms or make you uncomfortable?_____

_____

What are you using on your genital skin for washing, lubrication, or treatment? Please list any soaps, douches, powders, moisturizers, sprays, creams, ointments, or lubricants.

1. _____
2. _____
3. _____
4. _____
5. _____

How often do you wash your genital area? _____

Do you use a washcloth or loofah?_____

Do you wear panty liners? If so what brand?_____

Do you wear panty liners when you are not on your menstrual period?_____

Are you able to use tampons?_____

Have you ever had surgery? If yes, please list type of surgery and year it was done.

1. **_____**
2. **_____**
3. **_____**
4. **_____**
5. **_____**

Please check if you have ever been diagnosed with the following.

____Abnormal pap smear

____Genital warts

____Genital herpes

____Shingles

____Diabetes

____Eczema / Allergies

____Psoriasis

____Back pain or injury

____Irritable bowel syndrome

____TMJ or temporomandibular joint pain

____Anxiety

____Migraines

____Thyroid disease

____Sleep disorders

____Interstitial Cystitis

____Endometriosis

____Chronic Fatigue Syndrome

____Fibromyalgia

What do you think is causing your problem?_____

_____

Do you have any fears concerning this problem?_____

How does this affect your life?_____

_____

Is there anything else you would like us to know?_____

_____

_____

_____