

A	<b>Current Health Problem</b>
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1. Please indicate which option best describes why you are visiting our clinic today:

- |  |  |
|--|--|
| <input type="checkbox"/> Vaginal Discharge         | <input type="checkbox"/> Vaginal or vulvar itching |
| <input type="checkbox"/> Vaginal or vulvar burning | <input type="checkbox"/> Pain with sex             |
| <input type="checkbox"/> Other: _____              |  |

2. How many months or years has it been since you *first* noticed **this problem**?

Months: \_\_\_\_\_ Years: \_\_\_\_\_

3. How many *other* health care providers have you seen for **this problem**?

Number (0 if none): \_\_\_\_\_

4. Which of the following names has **this problem** been called?

- |   |  |
|---|--|
| <input type="checkbox"/> Vestibulitis           | <input type="checkbox"/> Bacterial vaginosis or "BV" |
| <input type="checkbox"/> Yeast infection        | <input type="checkbox"/> Vulvodynia                  |
| <input type="checkbox"/> Lichen sclerosus       | <input type="checkbox"/> Lichen planus               |
| <input type="checkbox"/> Atrophic vaginitis     | <input type="checkbox"/> Vaginismus                  |
| <input type="checkbox"/> Desquamative vaginitis | <input type="checkbox"/> Other: _____                |

5. Can you pinpoint the exact day your symptoms started?  Yes  No

5a. **If yes**, what triggered the symptoms? \_\_\_\_\_

6. What makes your symptoms **worse**? \_\_\_\_\_

7. What makes your symptoms **better**? \_\_\_\_\_

8. Do your symptoms get worse around the time of your period?  Yes  No

9. Do you have **burning** or **irritation** in your vagina or on your vulva **after sex**?  Yes  No

PT.NO. \_\_\_\_\_


NAME \_\_\_\_\_

DOB \_\_\_\_\_

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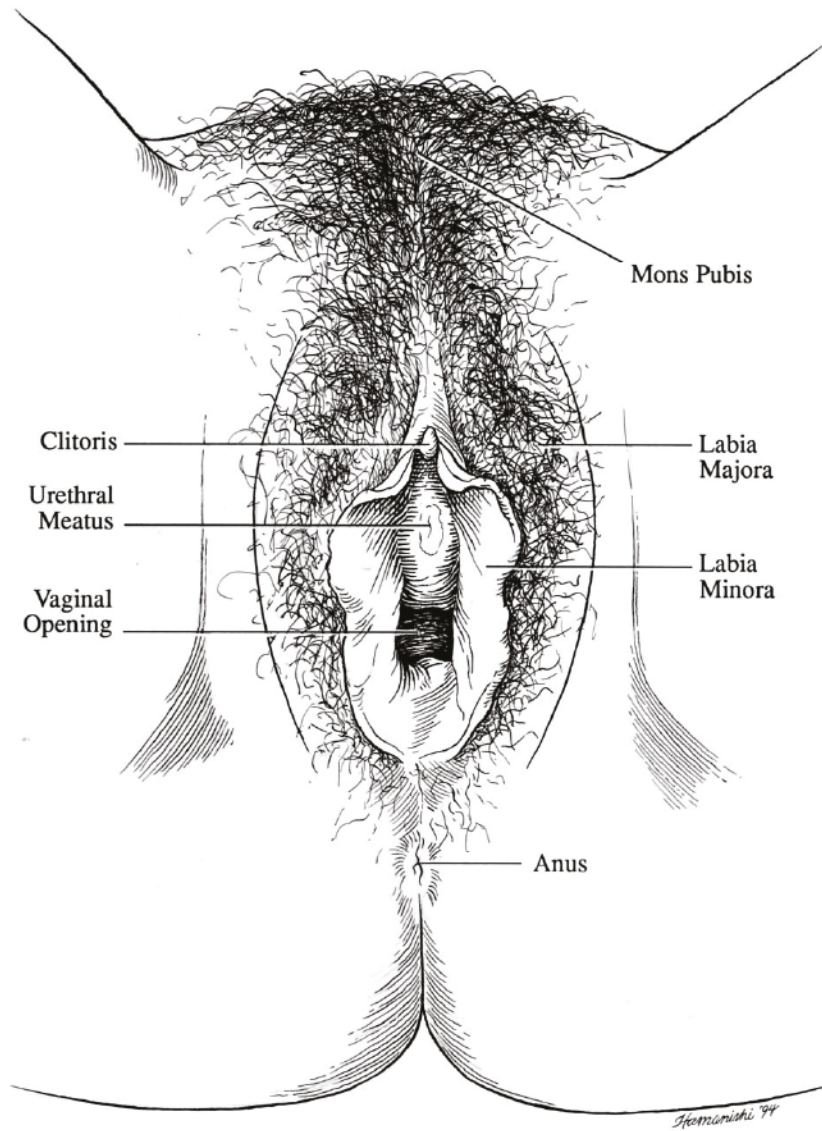
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10. Please describe your symptoms:

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Under the diagram, please mark the areas where you are having symptoms. You may make notes of where you have itching, burning, pain, etc...

PT.NO. \_\_\_\_\_

NAME \_\_\_\_\_

DOB \_\_\_\_\_

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11. Have you ever been diagnosed with a yeast infection?  Yes  No

11a. If yes, have you had more than 3 yeast infections diagnosed by a health care provider in the last year?

Yes  No

12. What of the following treatments have you received **specifically for this problem?** (Check all that apply)

None

Antibiotics

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  
Start date – End date

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  
Start date – End date

Anti-yeast medication

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  
Start date – End date

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  
Start date – End date

Estrogen pills or vaginal cream

Steroid Cream

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  
Start date – End date

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  
Start date – End date

Steroid Injections

How many total? \_\_\_\_\_

Physical therapy:

Name: \_\_\_\_\_ Location: \_\_\_\_\_ Duration: \_\_\_\_\_  
Start date – End date

Antidepressants (i.e. nortriptyline, amitriptyline, duloxetine)

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  
Start date – End date

Nerve medications (i.e. gabapentin, pregabalin)

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  
Start date – End date

Vaginal Lubricants

Name: \_\_\_\_\_

Other (including herbal and alternative therapies): \_\_\_\_\_

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13. How often did you feel:

	Never	Rarely	Occasionally	Frequently	Always
14. Distressed about your sex life	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
15. Unhappy about your sexual relationship	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
16. Guilty about sexual difficulties	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
17. Frustrated by your sexual problems	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
18. Stressed about sex	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
19. Inferior because of sexual problems	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
20. Worried about sex	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
21. Sexually inadequate	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
22. Regrets about your sexuality	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
23. Embarrassed about sexual problems	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
24. Dissatisfied with your sex life	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
25. Angry about your sex life	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
26. Bothered by low sexual desire	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

Female Sexual Distress Scale. *Derogatis L, et al. J Sex Med. 2007 Nov 27*

27. Are you currently sexually active?  Yes  No

28. Do you feel that you have adequate lubrication?  Yes  No  Not applicable

29. Do you use any vaginal lubricants?  Yes  No  Not applicable

29a. **If yes**, what brand(s)? \_\_\_\_\_

30. Do you have pain with intercourse?  Yes  No  Not applicable

31. Are you able to achieve orgasm?  Yes  No  Not applicable

PT.NO. \_\_\_\_\_

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DOB \_\_\_\_\_

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32. Which of the following do you consider to be your ethnic or racial group?

- Hispanic or Latina (Cuban, Mexican, Puerto Rican, South/Central American or other Spanish Origin)
- African American / Black
- Asian
- American Indian or Alaskan Native
- Caucasian / White
- Native Hawaiian or Pacific Islander
- Other (Please specify): \_\_\_\_\_

33. What best describes your present marital/partner status?

- Married or living with a partner
- Single, not living with a partner
- Divorced or separated
- Widowed

34. How many years of formal education have you received?

- Less than high school (8 years or less)
- High School graduate (12 years)
- College Graduate (16 years)
- Some high school (9-11 years)
- Some college / technical school (13-15 years)
- Graduate School (>17 years)

35. What is your employment?

- Full-time
- In school or vocational training
- Homemaker
- Disabled
- Part-time
- Retired
- Unemployed
- Other: \_\_\_\_\_

36. Many of our patients living with depression, anxiety, relationship problems or chronic pain benefit from having a multidisciplinary approach to their pain management. Would you like a referral to psychiatry or social work?  Yes  No

PATIENT SIGNATURE

DATE

PT.NO

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