



SPECTRUM

DERMATOLOGY OF SEATTLE

VULVAR SYMPTOM QUESTIONNAIRE

Patient name: _____

Today's date: _____

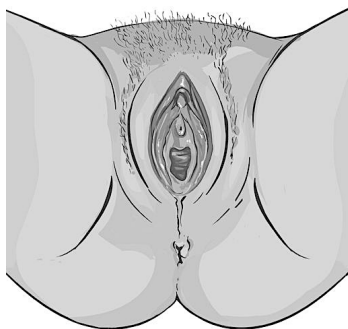
1. What is the reason for your visit today?

2. Age of onset of vulvar symptoms _____. (This was _____ years ago).

3. On a scale of 0 (no symptoms) to 10 (worst symptoms imaginable), what is your level of vulvar discomfort?

- a. Vulvar symptoms today 0.....10
- b. Vulvar symptoms on an average day 0.....10
- c. Vulvar pain/discomfort during sexual touch 0.....10

4. Where are you symptoms located? (Please use the diagram if you find it helpful)



5. Please check the relevant symptoms:

- | | | | |
|---|---------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Itching | <input type="checkbox"/> Pain/burning | <input type="checkbox"/> Abnormal Discharge | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Skin splitting | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Unusual odor | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> White patches | <input type="checkbox"/> Rawness | <input type="checkbox"/> Redness | |

6. Are your symptoms:

- Constant Intermittent With intercourse or touch to the area
 Getting worse Getting better

7. Does anything make your symptoms better? No____ Yes____

Describe _____

8. Does anything make your symptoms worst? No____ Yes____

Describe _____

- 9. Do your symptoms limit the time you can sit, do activities or do sports? No___ Yes___
- 10. Do dietary factors affect your symptoms? No___ Yes___
- 11. Do you have bladder or pelvic pain? No___ Yes___
- 12. Do you have pain, urgency or frequency of urination? No___ Yes___
- 13. Do you leak urine? No___ Yes___
- 14. Can you use tampons? No___ Yes___
- 15. Are speculum exams painful? No___ Yes___
- 16. Do you use artificial lubricants for intercourse? No___ Yes___
- 17. Have you ever had a yeast infection? No___ Yes___

When was the last time you had a yeast infection? _____

- 18. Have you ever had a biopsy of the vulva? No___ Yes___

When: _____

By Whom: _____

Results: _____

- 19. What treatments have been tried for your symptoms? Did it help?

Creams or ointments:

1. _____ No___ Yes___

2. _____ No___ Yes___

3. _____ No___ Yes___

Oral medicines:

1. _____ No___ Yes___

2. _____ No___ Yes___

3. _____ No___ Yes___

- 20. Other therapies tried: (please check any that apply)

Steroid Injections Dietary changes Sexual counseling

Surgery Physical therapy Laser

- 21. Please describe any other symptoms or provide any other information you think would be helpful for me to know.

Thank you for taking the time to fill out this lengthy questionnaire. It is very helpful to me in understanding your symptoms and creating a treatment plan for you. I value the trust you have placed in me and hope to earn that trust.

Paula D. Zook, MD