SPECTRUM
DERMATOLOGY OF SEATTLE

VULVAR SYMPTOM QUESTIONNAIRE

Patient name: _____________________________________ Today's date: ___________________

1. What is the reason for your visit today?

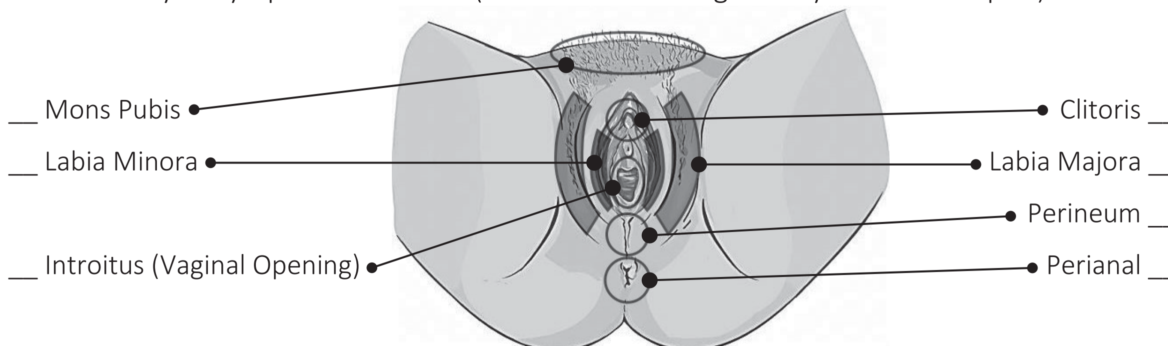
____

____

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?

	1	2	3	4	5	6	7	8	9	10
a. Vulvar symptoms today										
b. Vulvar symptoms on an average day										
c. Vulvar pain/discomfort during sexual touch										

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



5. Please check the relevant symptoms:

__ Itching __ Pain/burning __ Abnormal Discharge __ Dryness

__ Skin splitting __ Bleeding __ Unusual odor __ Swelling

__ White patches __ Rawness __ 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.

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