WEST SUBURBAN
WOMEN'S HEALTH

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Dr. Carla Carpenter
Dr. Jamie Januszyk
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VULVAR PAIN QUESTIONNAIRE

Purpose: To clearly identify the symptoms surrounding vulvar pain.

Name_____ Age_____ Country of Birth_____

Race_____

Marital status: Single Married Significant Other Divorced Widowed

Educational level: high school college graduate school

Or, years of education: 1-8 8-12 above 12

Profession _____

Estrogen status: (circle one) premenopausal

postmenopausal using estrogen replacement by mouth or patch

postmenopausal using estrogen replacement by vaginal cream or tablet

postmenopausal not using estrogen replacement

At what age did you experience menopause: _____

1. Symptoms: circle all that apply

Burning Stinging Rawness Irritation Sores

Itching Stabbing Knife-Like Paper Cuts Aching

Pelvic Pain Pelvic Pressure Other_____

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All symptoms will be referred to as "pain" although you may not experience pain but rather burning, irritation, rawness etc.

2. Date that symptoms began. If different symptoms began at different times, please indicate the onset of each symptom. Are the symptoms constant, or off and on?

_____

_____

_____

_____

3. If you have pain with intercourse, how long after first intercourse did this happen?

_____

4. Have you ever had intercourse without pain? yes no

5. Did anything happen that started your pain? (surgery, birth of a child, vaginal infection)

_____

_____

6. Does touching of the area produce pain? yes no

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7. Which of the following produces pain? circle all that apply

Sexual intercourse yes no

If yes: With initial penetration
During all time that penetration is occurring
After intercourse
With all partners

Insertion of tampon	yes	no
Menstrual pads	yes	no
Wearing tight clothing	yes	no
Riding a bicycle	yes	no
Urination	yes	no
Pain in the absence of intercourse	yes	no
Partner touching	yes	no
Cold	yes	no
Heat	yes	no
Sweating	yes	no
Stress	yes	no
Fear	yes	no

Are any of your vulvar symptoms relieved by any of the following? (Circle those that apply)

Heat	Shower	Alcohol	Sitz bath	Exercise
Hot tub	Lying down	Standing	Sitting	Tub bath
Loose clothing	No underwear			

8. Do you have pain in the area when nothing is touching it? yes no

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9. Are your symptoms worse ? Circle all that apply

with periods during periods after periods no relation to periods

not having periods/doesn't apply

10. Rate the INTENSITY of the pain

_____

(0=none) (10=worst imaginable)

11. Rate the UNPLEASANTNESS of the pain

_____

(0=none) (10=worst imaginable)

12. Does the pain radiate to other parts of your body? Yes No

13. Does the pain wake you from sleep? Yes No

Other problems:

Do you have?

1. Constipation? Yes No

2. Diarrhea? Occasionally (not more than 3 times a year)

Often/usually

3. Do you have problems with urination? Burning or stinging

Difficulty starting stream

Leaking urine

Sudden need to urinate

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4. Which of the following do you have? (Circle any that apply)

Fibromyalgia	Low energy	Depression	Frequent headaches
Low thyroid	High blood pressure	Difficulty sleeping	Hay fever/ seasonal allergies
Chronic fatigue	Skin sensitivities	Pelvic pain	Diabetes

Previous treatment: Please circle any medications you have used and circle to your response to the medication.

Type of therapy:	The therapy made me:		
Yeast medication	Worse	Better	No change
Steroid creams or ointments	Worse	Better	No change
Steroids by mouth	Worse	Better	No change
Estrogen cream	Worse	Better	No change
Testosterone cream or ointment	Worse	Better	No change
Tricyclic medication (amitripyline, desipramine, imipramine)	Worse	Better	No change

If yes, what medication, what dose did you reach and how long did you take it? Did you note change in Symptoms?

_____

_____

Other antidepressant medication
(if yes, what medication, what dose did
you take and for how long?) Any symptom change?

_____

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Type of therapy:	The therapy made me:		
Narcotic pain medication such as codiene, oxycodone, hydrocodone	Worse	Better	No change
Soaks (Aveeno, Burrow's Domeborrows)	Worse	Better	No change
Moisturizers (Replens, KY, Vaseline, Aquafor)	Worse	Better	No change
Gabepentin or Lyrica (Add dose and length of treatment)	Worse	Better	No change
Topical anesthetics (Lidocaine, Vagisil)	Worse	Better	No change

Other medication (please list including dose and length of treatment)

_____

_____

_____

Pelvic floor rehab/biofeedback	Worse	Better	No change
Vestibulectomy	Worse	Better	No change

Other surgery (list then circle response)

_____

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Personal Hygiene history

Laundry detergent brand _____

Fabric softener brand _____

Dryer sheets _____

Body soap _____

Wash with? Hand Towel Scrub brush

Psychological history

Have you ever been treated for:	Yes No		
If yes, treatment?	Medication	Counseling	Hospitalization
Anxiety	Yes No		
If yes, treatment?	Medication	Counseling	Hospitalization
Bipolar disorder	Yes No		
If yes, treatment?	Medication	Counseling	Hospitalization
Schizophrenia	Yes No		
If yes, treatment?	Medication	Counseling	Hospitalization

Family history

Do you have any family members with vulvar disorders? Please detail

_____

_____

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Allergy history

Please list any allergies and include any sensitivities to skin products that you have experienced?

_____

_____

Health history

Do you ?

Smoke cigarettes Yes No Former

If yes _____ packs per day

Drink alcohol Yes No Former

If yes _____ drinks per week

Smoke marijuana Yes No Former

If yes _____ times per week

Take medications not prescribed to you Yes No Former

If yes _____ times per week

Exercise Yes No

If yes _____ times per week

Sleep _____ hours per night on average

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Sexual History

1. Have you ever been sexually active? Yes No
   If yes, please answer the following questions :
   Have you been sexually active in the last 6 months? Yes No
   Age at first intercourse? _____
   Number of lifetime sexual partners (approximate): _____

2. Current Relationship Status (circle one):
   Single Married Cohabitating Widowed (When :_____)
   Separated/Divorced (When :_____) In a stable relationship (How long :_____)

3. How would you describe your sexuality?
   Heterosexual (sex with men)
   Bisexual (sex with men and women)
   Lesbian (sex with women)

4. Please mark any that apply to your current sexual activity:
   None Vaginal Sex Masturbation Oral Sex Anal Sex
   Mutual Stimulation by Partner Instruments for Orgasm (i.e. vibrator, sex toys)

5. Quality of **current** sexual activity:
   Generally very satisfying
   Sometimes satisfactory
   Rarely satisfactory
   Never

6. Quality of sexual activity **prior to symptoms**:
   Generally very satisfying
   Sometimes satisfactory
   Rarely satisfactory
   Never

7. **Frequency** of sexual activity:
   2 or more times per week
   Once per week
   2-3 times per month
   Once per month
   Less than once per month
   Rarely
   Never sexually active

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8. Are you orgasmic? Always
Sometimes
Very Infrequently
Never

If yes, by:

Partner Stimulation	Yes	No
Masturbation	Yes	No
Vaginal Intercourse	Yes	No
Anal Intercourse Sex	Yes	No
Oral Sex	Yes	No

9. Are you currently involved in a relationship outside of your primary relationship? Yes No
If yes, duration:_____

10. Recent change or divorce regarding partner? Yes No
If yes, what change:_____

11. Number of partners since vulvar pain symptoms began (if applicable): _____

Please circle the number that most closely applies to you for the following questions.

12. I am **interested** in sex: 1 2 3 4 5
(No Interest) (High Interest)

13. How do you feel about yourself as a **sexual person**? 1 2 3 4 5
(Negative) (Positive)

14. **Vaginal** sexual activity is important to me: 1 2 3 4 5
(Not important) (Very Important)

15.Do you use **lubricants** with vaginal intercourse? Always
Sometimes
Never

If yes, what type: _____

16. Does your partner have sexual difficulty? Yes
No
Uncertain

If yes, please check all that apply:

Erection difficulties	Yes	No
Rapid ejaculation	Yes	No
Fear of Hurting	Yes	No
Low Sexual Desire	Yes	No
Other (please describe):	_____	

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Have you ever been the victim of emotional abuse: Yes No No Answer

Please circle an answer for both age groups for the following questions:	Age 13 & Younger		Age 14 & Older	
	Yes	No	Yes	No
Has anyone ever exposed the sex organs of their body to you when you did not want it?	☐	☐	☐	☐
Has anyone ever threatened to have sex with you when you did not want it?	☐	☐	☐	☐
Has anyone ever made you touch the sex organs of their body when you did not want to?	☐	☐	☐	☐
Have you had any other unwanted sexual experiences not mentioned above?	☐	☐	☐	☐
If yes, please specify:				

When you were 13 or younger, did an older person do the following?	Never	Seldom	Sometimes	Often
Hit, kick, or beat you?	☐	☐	☐	☐
Seriously threaten your life?	☐	☐	☐	☐
When you were 14 or older, did an older person do the following?	**Never**	**Seldom**	**Sometimes**	**Often**
Hit, kick, or beat you?	☐	☐	☐	☐
Seriously threaten your life?	☐	☐	☐	☐

Do you know or suspect sexual or physical abuse to any of your siblings? Yes No Uncertain

Does sexual activity bring up negative thoughts and remind you of past trauma? Yes No Uncertain

If yes, what concerns do you have? (please describe)

_____

_____

_____

_____

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Review of Symptoms: Please mark any symptoms that you have experience in the last three months.

General	✓ = Yes	**Gastrointestinal**	✓ = Yes
Chronic Fatigue		Nausea or Vomiting	
Fevers		Poor Appetite	
Difficulty falling or staying asleep		Abdominal bloating/fullness	
Unintentional Weight Loss		Heartburn	
Unintentional Weight Gain		Constipation	
Skin		Diarrhea	
Rash		Blood in stools	
Itching		Pain with Bowel movements	
Pigmented or colored mole		**Urinary**	
Head and Neck		Urinary frequency	
Itchy Eyes		Urgency	
Sore Throat		Urine leaking	
Mouth sores or ulcers		Pain in urination	
Bleeding gums		Blood in urine	
Heart		Incomplete bladder emptying	
Chest pain		Night time urination (>2 / night)	
Irregular heart beat		**Musculoskeletal**	
Ankle/foot swelling		Muscle or joint pain	
Lungs		Body aches or stiffness	
Shortness of breath		Leg pain	
Chronic cough		Back pain	
Wheezing		**Neurologic**	
Endocrine		Headaches	
Excess hair growth		Dizziness	
Nipple discharge		Memory Loss	
Hot Flashes		Low attention	