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 ________________________________
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
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
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
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
  - Worse
  - Better
  - No change
  (amitriptyline, desipramine, imipramine)

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?
<table>
<thead>
<tr>
<th>Type of therapy</th>
<th>The therapy made me:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcotic pain medication such as codeine, oxycodone, hydrocodone</td>
<td>Worse  Better  No change</td>
</tr>
<tr>
<td>Soaks (Aveeno, Burrow’s Domeborrows)</td>
<td>Worse  Better  No change</td>
</tr>
<tr>
<td>Moisturizers (Replens, KY, Vaseline, Aquafor)</td>
<td>Worse  Better  No change</td>
</tr>
<tr>
<td>Gabepentin or Lyrica (Add dose and length of treatment)</td>
<td>Worse  Better  No change</td>
</tr>
<tr>
<td>Topical anesthetics (Lidocaine, Vagisil)</td>
<td>Worse  Better  No change</td>
</tr>
<tr>
<td>Other medication (please list including dose and length of treatment)</td>
<td></td>
</tr>
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</table>

Pelvic floor rehab/biofeedback | Worse  Better  No change       |
Vestibulectomy                 | Worse  Better  No change       |
Other surgery (list then circle response) | |

West Suburban Women’s Health  545 Plainfield Rd, Ste C, Willowbrook, IL 60527  (Phone) 630-654-BABY (Fax) 630-655-3270
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

If yes, treatment? Medication Counseling Hospitalization

Bipolar disorder

If yes, treatment? Medication Counseling Hospitalization

Schizophrenia

If yes, treatment? Medication Counseling Hospitalization

Family history

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

__________________________________________________________
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
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 Cohabiting 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 Mutual Stimulation by Partner
   Masturbation Oral Sex Anal Sex
   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
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  
      (No Interest)
    - 2
    - 3
    - 4
    - 5
      (High Interest)

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

14. Vaginal sexual activity is important to me:  
    - 1  
      (Not important)
    - 2
    - 3
    - 4
    - 5
      (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): __________________________
Have you ever been the victim of emotional abuse:  Yes  No  No Answer

<table>
<thead>
<tr>
<th>Please circle an answer for both age groups for the following questions:</th>
<th>Age 13 &amp; Younger</th>
<th>Age 14 &amp; Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has anyone ever exposed the sex organs of their body to you when you did not want it?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Has anyone ever threatened to have sex with you when you did not want it?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Has anyone ever made you touch the sex organs of their body when you did not want to?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you had any other unwanted sexual experiences not mentioned above?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>If yes, please specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When you were 13 or younger, did an older person do the following? | Never | Seldom | Sometimes | Often |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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</tr>
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<tbody>
<tr>
<td>Hit, kick, or beat you?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Seriously threaten your life?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

When you were 14 or older, did an older person do the following? | Never | Seldom | Sometimes | Often |
<table>
<thead>
<tr>
<th></th>
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<td>□</td>
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<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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

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