**SECTION 1: REASON FOR VISIT**

Which of the following doctors have you seen for this problem?

|  |  |  |
| --- | --- | --- |
| Family Doctor | Walk-in Clinic Doctor | Gynaecologist |
| Dermatologist | Urologist | Other: |

|  |  |  |
| --- | --- | --- |
| Have you been given a diagnosis? | Yes | No |
| Do you agree with the diagnosis? | Yes | No |

Briefly describe the reason for your visit today?

**SECTION 2: VULVAR SYMPTOMS**

Which of the following vulvar symptoms apply to you at this time? Check all that apply. If you do NOT have symptoms Go to SECTION 3

|  |  |  |
| --- | --- | --- |
| Itch | Urge to scratch | Burning |
| Soreness, rawness | Stabbing, pinching | Dryness |
| Numbness | Sexual discomfort | Unable to have sexual intercourse/penetration |

In general how would you rate your symptoms **over the last 4 weeks**?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| None | Mild | Moderate | Severe | Very Severe |

How long have you had symptoms?      months      years

Where are your symptoms located? Check all that apply

|  |  |  |  |
| --- | --- | --- | --- |
| Mons – above the pubic bone | Hair bearing large lips of vulva | Hairless inner lips of vulva | Entrance to vagina |
| Inside of vagina | Around the anus | Buttocks | Other |

|  |  |  |
| --- | --- | --- |
| Do your symptoms spread to other areas? | Yes | No |

Are your symptoms – check all that apply?

|  |  |  |  |
| --- | --- | --- | --- |
| Constant | Come and go daily | Come and go weekly/monthly | Cyclic – relative to the menstrual cycle |

Since your symptoms began have your symptoms?

|  |  |  |  |
| --- | --- | --- | --- |
| Improved | Worsened | Stayed the same | Went away completely and then came back again |

|  |  |  |
| --- | --- | --- |
| Are there any factors that make your symptoms better? | Yes | No |
| Are there any factors that make your symptoms worse? | Yes | No |

Do your symptoms interfere with – (check all that apply)

|  |  |  |
| --- | --- | --- |
| Clothing choices | Exercise | Sitting |
| Caring for children | Household chores | Sleep |
| Employment | Walking | Sexual activity |

**SECTION 3: GENITAL SIGNS**

Have you noticed any of the following changes **over the last 4 weeks**?

Check all that apply or check **NONE**

|  |  |  |
| --- | --- | --- |
| Abnormal vaginal bleeding | Erosions (raw areas) | Ulcers |
| Abnormal vaginal discharge | Rash | Vulvar discharge |
| Bleeding after vaginal intercourse | Rectal bleeding | Vulvar swelling |
| Blisters | Red areas of skin | Vulvar bleeding |
| Brown/black areas of skin | Sores, cuts or raw areas | White areas of the skin |
| Bumps | Splitting of skin | **NONE** |

Are there any other changes to the genital skin that you have noticed?

|  |  |
| --- | --- |
| Yes DESCRIBE: | No |

Have you had a vulvar skin biopsy – when by whom what was the result?

|  |  |
| --- | --- |
| Yes - When?       Result? | No |

**SECTION 4: GENITAL HYGEINE**

|  |  |  |
| --- | --- | --- |
| How often do you wash the vulva? | # per | |
| Do you remove your pubic hair? | Yes | No |
| Please check all of the following that you use in the genital area – | | |
| Bar soap  Barrier cream  Bubble bath, bath oils or salts  Feminine hygiene sprays  Lubricants  Incontinence pads | Menstrual cups  Menstrual pads  Oils  Perfumes  Lubricants  Powders  Skin cleansers | Shaving cream  Tampons  Vaginal douches  Wash cloths to clean  Washes or toilettes  Wax  Other not listed |

**SECTION 5: GYNAECOLOGICAL HISTORY**

**PAST GYNECOLGICAL INFECTION:** Check any that apply or check **NONE**

|  |  |  |
| --- | --- | --- |
| Bacterial Vaginosis | Genital warts | Pelvic Inflammatory Disease |
| Chlamydia | Gonorrhea | Syphilis |
| Frequent bladder infections | Herpes – genital | Other: |
| Frequent yeast infections | HIV/AIDS | **NONE** |

|  |  |  |
| --- | --- | --- |
| Have you ever been pregnant? | Yes | No |
| Do you have menstrual periods? | Yes | No |
| Are your periods regular? | Yes | No |
| Do you have bleeding or spotting between periods? | Yes | No |
| Are you currently using birth control? | Yes | No |
| Have you been vaccinated against HPV? | Yes | No |
| Have you had any abnormal pap smears? | Yes | No |
| Have you ever been diagnosed with a pre-cancer lesion of the vulva, vagina and or cervix? | Yes | No |
| I you have stopped menstruating at what age did your period’s stop? | Age? | |
| Have you ever been on hormone replacement therapy? | Yes | No |
| Are you currently on HRT? | Yes | No |
| Are you currently sexually active? | Yes | No |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **DERMATOLOGY LIFE QUALITY INDEX** | | | | | | |
|  | Very much | | A lot | A little | Not at all | Not relevant |
| Over the last week, how itchy, sore, painful or stinging has your skin been? |  | |  |  |  |  |
| Over the last week, how embarrassed or self conscious have you been because of your skin? |  | |  |  |  |  |
| Over the last week, how much as your skin interfered with you going shopping or looking after your home or garden? |  | |  |  |  |  |
| Over the last week, how much as your skin influenced the clothes you wear? |  | |  |  |  |  |
| Over the last week, how much as your skin affected any social or leisure activities |  | |  |  |  |  |
| Over the last week, how much as your skin made it difficult to do any sport? |  | |  |  |  |  |
| Over the last week has your skin prevented you from working or studying? |  | |  |  |  |  |
| Over the last week, how much as your skin created problems with your partner or any of your closer friends or relative? |  | |  |  |  |  |
| Over the last week, how much as your skin caused any sexual difficulties? |  | |  |  |  |  |
| Over the last week, how much of a problem has the treatment for your skin been? For example, my making your home messy or taking up time? |  | |  |  |  |  |
|  | |  | | | | |

**Please check you have answered EVERY question. Thank you.** AY Finlay, GK Khan, April 1992 www.dermatology.org.uk, this must not be copied without the permission of the authors.

**SECTION 6 PAST MEDICAL HISTORY**: Check any that apply or check **NONE**

|  |  |  |
| --- | --- | --- |
| Alcoholism | Heart disease | Lung disease |
| Arthritis | High blood pressure | Mental Illness |
| Autoimmune disease | Heartburn, ulcer | Nerve condition |
| Blood clot lungs/legs | Hepatitis | Osteoporosis |
| Cancer | Headaches (migraine, tension) | Past blood transfusions |
| Diabetes | Interstitial cystitis | Thyroid disease |
| Drug abuse/addiction | Irritable bowel | Stroke |
| Endometriosis | Kidney disease | **NONE** |
| Fibromyalgia/Chronic Fatigue Syndrome | Liver disease | OTHER |

Please describe OTHER Medical Problems:

|  |
| --- |
| SECTION 7 PAST SURGICAL HISTORY: Check any that apply or check NONE |

|  |  |  |
| --- | --- | --- |
| Appendix  Bladder surgery  Bowel surgery  Breast surgery  Caesarean section  D& C  Eisiotomy repair | Gallbladder  Heart surgery  Hip surgery  Hysterectomy  Hysteroscopy  Infertility surgery  Knee surgery | Laparoscopy  Ovarian surgery  Tubal ligation  Vaginal surgery  Vulvar surgery  NONE  OTHER |

Please describe OTHER Surgery:

SECTION 8 MEDICATIONS AND ALLERGIES

|  |  |
| --- | --- |
| Current Medications | Allergies |
| None | None |
| Yes, If so please list below | Yes, If so please list below |
|  |  |
|  |  |
|  |  |

Thank you for taking the time to complete this questionnaire