**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