SLUCare Physician Group

MRN #: _____

Please print legibly

Vulvar Vaginal Disorders Clinic

Patient Questionnaire

Patient's Name: _____ Date Form Completed: _____

Date of Birth: _____ Occupation: _____ ☐ Unemployed ☐ Retired

Physician Information

Name of Referring Physician: _____ Address: _____

Name of Primary Physician: _____ Address: _____

_____

Present Condition

1. Please check any of the symptoms below which have led you to seek medical attention here:

☐ Painful intercourse ☐ Vulvar itching ☐ Vulvar burning ☐ Burning after intercourse
☐ Vaginal discharge ☐ Vulvar pain ☐ Clitoral pain ☐ Other
☐ Vaginal itching ☐ Vaginal burning ☐ Urinary problems

2. How long have you had these symptoms? _____
3. Did the symptoms start with any major life or gynecological events? (Marriage, childbirth, hysterectomy, surgery, bronchitis, new illness)? Yes No _____
4. Has your condition been given a name? Yes No _____
5. Have you had previous vulvar biopsies for this condition? Yes No
6. What medicines have you been treated with for this condition? _____
7. What medicine or treatment are you using **now** for this condition? _____
8. Do your symptoms prevent you from doing any activities? Yes No
   If yes, specify: ☐ Working ☐ Exercise ☐ Participating in social activities ☐ Travel ☐ Sexual activities
   ☐ Other _____
9. Do you have a history of any sexually transmitted disease? Yes No If yes, specify: _____
10. Does your partner have symptoms of irritation, itching, burning or discharge? Yes No
11. Have you used any hormone therapy? Yes No If yes, how long: _____
12. Have you used hormonal contraceptives? Yes No If yes, how long: _____
13. Have your symptoms caused you to feel any of the following:

Yes	No	Fear of having to live with chronic pain
Yes	No	Loss of previously satisfying sex life
Yes	No	Relationship problems with your partner
Yes	No	Isolation due to private nature of problem
Yes	No	Are you able to discuss the problem with family members or friends
Yes	No	Fear of possible cancer
Yes	No	Emotional, moody. frustrated and/or angry
Yes	No	Fear of having a disease that you may give to others
Yes	No	Antidepressant or anxiolytic use

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Medical Problems Please check yes or no for each problem you are having:

☐ Yes	☐ No	Abnormal pap	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Chlamydia
☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Congestive heart failure
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Cataracts	☐ Yes	☐ No	Emphysema/COPD
☐ Yes	☐ No	Crohn's disease/ Ulcerative colitis	☐ Yes	☐ No	Congenital heart disease	☐ Yes	☐ No	Gestational diabetes
			☐ Yes	☐ No	DVT (blood clots)	☐ Yes	☐ No	Heart attack
☐ Yes	☐ No	Depression	☐ Yes	☐ No	Fibromyalgia	☐ Yes	☐ No	Viral hepatitis
☐ Yes	☐ No	Epilepsy/seizures	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	HIV/AIDS
☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Heart problems	☐ Yes	☐ No	Irritable bowel syndrome
☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No	Kidney stones
☐ Yes	☐ No	Heartburn/GERD	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No	Pulmonary embolus
☐ Yes	☐ No	HPV	☐ Yes	☐ No	Osteoporosis/ penia	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Interstitial cystitis	☐ Yes	☐ No	Sickle cell disease	☐ Yes	☐ No	Trichomonas
☐ Yes	☐ No	Migraines	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No	Type 2 diabetes
☐ Yes	☐ No	Sickle cell trait	☐ Yes	☐ No	Type 1 diabetes	☐ Yes	☐ No	Herpes
☐ Yes	☐ No	Syphilis	☐ Yes	☐ No	Anesthetic complications	☐ Yes	☐ No	Other (list)
☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Bladder/kidney infections			

Surgical History Tell us about surgeries you've had:

☐ Yes	☐ No	Appendectomy	☐ Yes	☐ No	Ovaries & tubes removed	☐ Yes	☐ No	Cervical biopsy
☐ Yes	☐ No	Cervical cerclage	☐ Yes	☐ No	Gallbladder removed	☐ Yes	☐ No	Cervical cone biopsy
☐ Yes	☐ No	C-Section	☐ Yes	☐ No	D & C	☐ Yes	☐ No	Heart bypass surgery
☐ Yes	☐ No	Hernia repair	☐ Yes	☐ No	Hysteroscopy	☐ Yes	☐ No	LEEP
☐ Yes	☐ No	Mastectomy	☐ Yes	☐ No	Single ovary removed	☐ Yes	☐ No	Ovarian cyst removed
☐ Yes	☐ No	Tonsillectomy	☐ Yes	☐ No	Abdominal hysterectomy	☐ Yes	☐ No	Vaginal hysterectomy
☐ Yes	☐ No	Tubal ligation	☐ Yes	☐ No	Vulvar biopsy	☐ Yes	☐ No	Other (list)

Social History Tell us about yourself and your habits:

Tobacco Use

- ☐ I currently smoke _____ pack(s)/day for _____ years
- ☐ I have never smoked
- ☐ I used to smoke, but quit in _____
- ☐ I have only been exposed to passive smoke (other smoke, but not me)
- ☐ I use chewing tobacco

Alcohol Use

- ☐ I do not drink alcohol
- ☐ I currently use alcohol, and drink about _____ drinks a week

Street Drug Use

- ☐ Yes, I use street drugs List kinds: _____
- ☐ No, I don't use street drugs

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Gynecological History

Are you sexually active? Yes No

Do you use birth control? Yes No If yes, I use: _____

Last menstrual period: _____

Total pregnancies: _____ Number of deliveries: _____ Number of living children: _____

Weight of largest baby born vaginally: _____

Number of deliveries using forceps: _____ Number of deliveries using vacuum: _____

Torn into rectum during delivery of baby(s)? Yes No

Last Pap smear: Date _____ ☐ Normal ☐ Abnormal

Last Mammogram: Date _____ ☐ Normal ☐ Abnormal

Family History What have your family members suffered from medically?

Medical Problem	**Which Relative(s) Had This?**
Diabetes	
Breast cancer	
Ovarian cancer	
Colon cancer	
Osteoporosis	
Heart disease	
Hypertension	
Hyper cholesterol	
Deep vein clot	
Clot in lung	
Depression	
Stroke	
Heart failure	
Thyroid disease	
Other:	

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Review of Systems Please check those that have bothered you in the last few months:

Constitutional
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fevers
- ☐ Chills
- ☐ Decreased appetite
- ☐ Sweats
- ☐ Night sweats
- ☐ Headache

Eyes
- ☐ Blurry vision
- ☐ Light bothers eyes
- ☐ Double vision

Head and Neck
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Ear drainage
- ☐ Nasal congestion
- ☐ Bloody nose
- ☐ Snoring
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness

Respiratory
- ☐ Cough
- ☐ Asthma
- ☐ Sputum
- ☐ Spitting up blood
- ☐ Allergic rhinitis
- ☐ Wheezing
- ☐ Shortness of breath on exertion

Cardiovascular
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Irregular heartbeat
- ☐ Murmur
- ☐ Fainting
- ☐ Rapid heart rate

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Indigestion
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Change in bowel habits
- ☐ Black or bloody stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Jaundice
- ☐ Fluid in abdomen
- ☐ History of GI bleed
- ☐ Weight loss surgery

Genitourinary
- ☐ Urgency
- ☐ Difficult urination
- ☐ Blood in urine
- ☐ Waking up to urinate
- ☐ Painful urination
- ☐ Urinating very often
- ☐ Leaking urine
- ☐ Vaginal discharge

Integument/Breast
- ☐ Rash
- ☐ Skin lesions
- ☐ Itching
- ☐ Dryness
- ☐ Skin color change
- ☐ Change in mole
- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Breast tenderness

Hematologic/Lymphatic
- ☐ Easy bruising or bleeding
- ☐ Swollen glands
- ☐ Increased frequency of infections

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Stiff joints
- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Bone pain

Neurological
- ☐ Headache
- ☐ Migraines
- ☐ Seizures
- ☐ Vertigo
- ☐ Paralysis
- ☐ Numbness/tingling
- ☐ Tremor
- ☐ Involuntary movements

Behavioral/Psych
- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss
- ☐ Difficulty concentrating
- ☐ Phobias
- ☐ Problems sleeping

Endocrine
- ☐ Thyroid disease
- ☐ Goiter
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Diabetes
- ☐ Eating too much
- ☐ Drinking too much fluid
- ☐ Urinating too much
- ☐ Hair loss

Allergic/Immunologic
- ☐ Seasonal allergies
- ☐ Hay fever
- ☐ Itchy/watery eyes
- ☐ Frequent infections
- ☐ Atopic dermatitis/eczema
- ☐ Rashes