

WOMEN'S HEALTH CARE CENTER
VULVOVAGINAL SPECIALTY CLINIC
UNIVERSITY OF WASHINGTON DEPARTMENT OF OB/GYN

To: Patients of the Vulvovaginal Specialty Clinic

From: David Eschenbach, MD
Andrea Prabhu, MD
Alison North, ARNP

Welcome to the Vulvovaginal Specialty Clinic in the Women's Health Care Center at the University of Washington. We look forward to providing you with our expert opinion regarding your vulvovaginal concerns. As one of the only referral clinics for vulvovaginal issues in Washington, we often have a long wait time for appointments. To better serve you, we have enclosed some educational materials regarding basic skin care for the vulva. Please read and follow our Guidelines for Vulvar Skin Care while you wait for your appointment. Also, please discontinue all treatments you apply directly to the skin for your vulvovaginal symptoms. Often, these two measures can improve your symptoms and improve our ability to evaluate your problem.

A new patient history form is enclosed. Your history is often the most important component of your visit, and it will help us better understand your problem. Please complete the form as accurately as possible and bring it to your first appointment. We will review your history, and it will become part of your confidential patient record.

Finally, as an affiliate of the University of Washington School of Medicine, one of our goals is to learn more about vulvovaginal problems so that we can determine the best ways to diagnose and treat these issues. To that end, you are invited to participate in a registry of our patients. The registry will include information about your reasons for coming to the clinic, your diagnoses, and your treatments to help us learn about the conditions that we treat in this clinic and to provide us with a list of patients who may be interested in research studies in the future. *If you are interested in being included in the registry, read and sign the enclosed consent form and bring it to your clinic appointment or ask your provider more about this at your first appointment.* You will receive the same level of excellent care regardless of your participation in the registry.

We look forward to seeing you at your scheduled appointment. Thank you for your patience. Please call us at 206-598-5500 with questions.

DEPARTMENT OF OB/GYN
VULVOVAGINAL SPECIALTY CLINIC
GUIDELINES FOR VULVAR SKIN CARE

BATHING AND HYGIENE

1. Use unscented products/sensitive skin products for washing
 - a. Suggestions: Cetaphil, Neutrogena, Dove
2. Avoid using soap around the genitals. We recommend gentle rinsing with water only.
3. Avoid bubble baths and bath salts.
4. Avoid scrubbing, shaving, waxing, or vigorous drying of the genitals. Pat dry or use a hair dryer on a cool setting.
5. Avoid feminine sprays, douching, baby wipes, scented toilet paper, and scented pads and tampons. Consider use of all cotton pads/tampons.

LAUNDRY

1. Use unscented laundry detergent (no perfumes, no dyes).
 - a. Suggestions: All Free and Clear, Woolite Gentle Cycle
2. Use only the recommended amount of detergent for your washing machine, and consider double rinsing your underwear.
3. Avoid fabric softener or dryer sheets on any clothing or towels that contacts the vulva.

CLOTHING

1. Avoid pantyhose.
2. Remove bathing suit and any exercise clothes after activity.
3. Wear white, all cotton underwear. It is ok to sleep with no underwear at night.
4. Avoid tight fitting and synthetic fabric clothing.

LUBRICANTS AND SKIN CARE PRODUCTS

1. Use a water based lubricant (no fragrance)
 - a. Suggestions: Astroglide, Slippery Stuff
2. Coconut oil may be used for dry/cracked skin.
3. Do not douche.
4. Avoid spermicides, Vagisil, and Monistat.
5. Avoid over the counter creams and treatments unless told to use them.
6. Avoid genital hair removing products.

A	Current Health Problem
---	-------------------------------

1. Please indicate which option best describes why you are visiting our clinic today:

- | | |
|--|--|
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Vaginal or vulvar itching |
| <input type="checkbox"/> Vaginal or vulvar burning | <input type="checkbox"/> Pain with sex |
| <input type="checkbox"/> Other: _____ | |

2. How many months or years has it been since you *first* noticed this problem?

Months: _____ Years: _____

3. How many *other* health care providers have you seen for this problem?

Number (0 if none): _____

4. Which of the following names has this problem been called?

- | | |
|---|--|
| <input type="checkbox"/> Vestibulitis | <input type="checkbox"/> Bacterial vaginosis or "BV" |
| <input type="checkbox"/> Yeast infection | <input type="checkbox"/> Vulvodynia |
| <input type="checkbox"/> Lichen sclerosus | <input type="checkbox"/> Lichen planus |
| <input type="checkbox"/> Atrophic vaginitis | <input type="checkbox"/> Vaginismus |
| <input type="checkbox"/> Desquamative vaginitis | <input type="checkbox"/> Other: _____ |

5. Can you pinpoint the exact day your symptoms started?

Yes No

5a. If yes, what triggered the symptoms? _____

6. What makes your symptoms worse? _____

7. What makes your symptoms better? _____

8. Do your symptoms get worse around the time of your period?

Yes No

9. Do you have burning or irritation in your vagina or on your vulva after sex?

Yes No

PT. NO.	
NAME	
DOB	

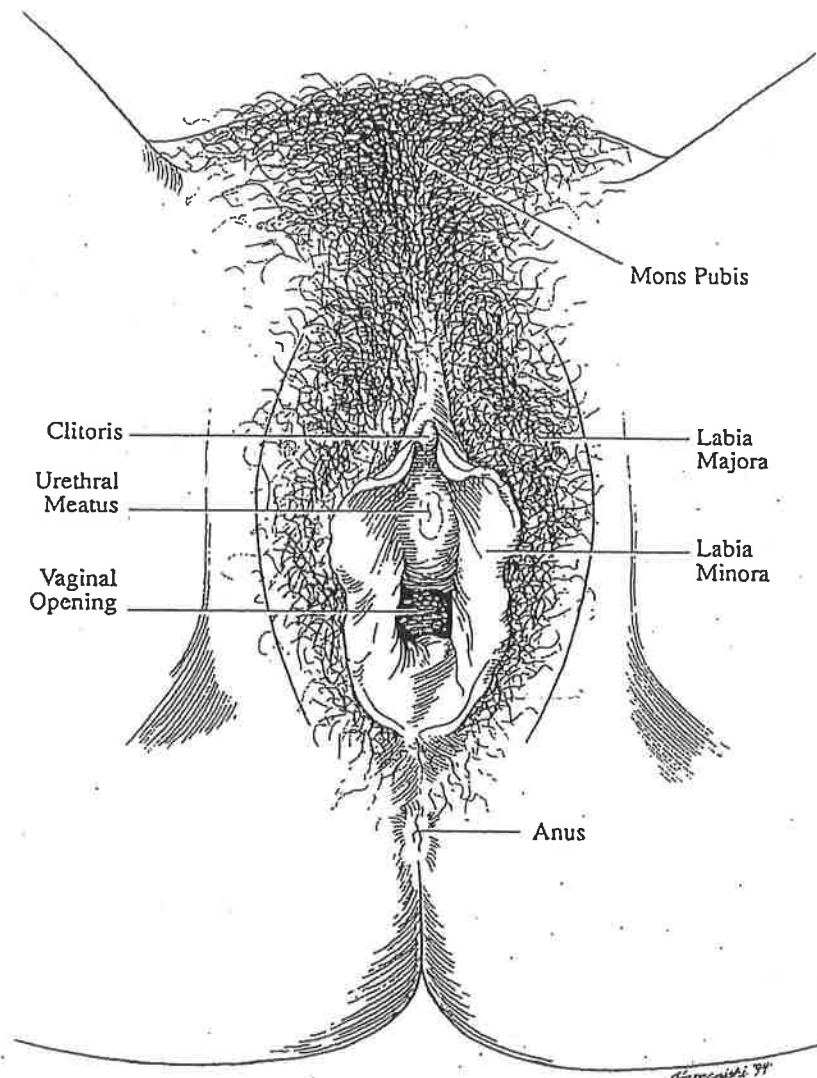
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Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

WHCC VULVOVAGINAL SPECIALTY CLINIC INTAKE
PAGE 1 OF 5



U3233

WHITE - MEDICAL RECORD



10. Please describe your symptoms:

Under the diagram, please mark the areas where you are having symptoms. You may make notes of where you have itching, burning, pain, etc. ...

PT.NO.

NAME

DOB

Place UIC Label Above Box

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U3233

WHITE - MEDICAL RECORD

UH3233 REV APR 13

11. Have you ever been diagnosed with a yeast infection? Yes No

11a. If yes, have you had more than 3 yeast infections diagnosed by a health care provider in the last year?
 Yes No

12. What of the following treatments have you received specifically for this problem? (Check all that apply)

None

Antibiotics

Name: _____ Dose: _____ Duration: _____
Start date – End date

Name: _____ Dose: _____ Duration: _____
Start date – End date

Anti-yeast medication

Name: _____ Dose: _____ Duration: _____
Start date – End date

Name: _____ Dose: _____ Duration: _____
Start date – End date

Estrogen pills or vaginal cream

Steroid Cream

Name: _____ Dose: _____ Duration: _____
Start date – End date

Name: _____ Dose: _____ Duration: _____
Start date – End date

Steroid Injections

How many total? _____

Physical therapy:

Name: _____ Location: _____ Duration: _____
Start date – End date

Antidepressants (i.e. nortriptyline, amitriptyline, duloxetine)

Name: _____ Dose: _____ Duration: _____
Start date – End date

Nerve medications (i.e. gabapentin, pregabalin)

Name: _____ Dose: _____ Duration: _____
Start date – End date

Vaginal Lubricants

Name: _____

Other (including herbal and alternative therapies): _____

PT.NO.

NAME

DOB

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U3233

WHITE - MEDICAL RECORD

UH3233 REV APR 13

B	Sexual Function
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13. How often did you feel:

	Never	Rarely	Occasionally	Frequently	Always
14. Distressed about your sex life	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
15. Unhappy about your sexual relationship	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16. Guilty about sexual difficulties	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17. Frustrated by your sexual problems	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18. Stressed about sex	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
19. Inferior because of sexual problems	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20. Worried about sex	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
21. Sexually inadequate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
22. Regrets about your sexuality	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23. Embarrassed about sexual problems	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
24. Dissatisfied with your sex life	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
25. Angry about your sex life	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
26. Bothered by low sexual desire	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Female Sexual Distress Scale. *Derogatis L, et al. J Sex Med. 2007 Nov 27*

27. Are you currently sexually active? Yes No

28. Do you feel that you have adequate lubrication? Yes No Not applicable

29. Do you use any vaginal lubricants? Yes No Not applicable

29a. If yes, what brand(s)? _____

30. Do you have pain with intercourse? Yes No Not applicable

31. Are you able to achieve orgasm? Yes No Not applicable

PT.NO. _____

NAME _____

DOB _____

Please attach label with this form

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U3233

WHITE - MEDICAL RECORD

32. Which of the following do you consider to be your ethnic or racial group?

- Hispanic or Latina (Cuban, Mexican, Puerto Rican, South/Central American or other Spanish Origin)
- African American / Black
- Asian
- American Indian or Alaskan Native
- Caucasian / White
- Native Hawaiian or Pacific Islander
- Other (Please specify): _____

33. What best describes your present marital/partner status?

- Married or living with a partner
- Divorced or separated
- Single, not living with a partner
- Widowed

34. How many years of formal education have you received?

- Less than high school (8 years or less)
- High School graduate (12 years)
- College Graduate (16 years)
- Some high school (9-11 years)
- Some college / technical school (13-15 years)
- Graduate School (>17 years)

35. What is your employment?

- Full-time
- In school or vocational training
- Homemaker
- Disabled
- Part-time
- Retired
- Unemployed
- Other: _____

36. Many of our patients living with depression, anxiety, relationship problems or chronic pain benefit from having a multidisciplinary approach to their pain management. Would you like a referral to psychiatry or social work? Yes No

PATIENT SIGNATURE

DATE

PT.NO.

NAME

Please Print Label with this info.

DOB

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U3233

WHITE - MEDICAL RECORD



University of Washington

Below is a list of locations of pain. In the first column, please indicate one or more areas where you have felt pain over the past week. In the second column, please indicate the ONE location of your most severe pain:

LOCATION	ANY PAIN? (√ ALL THAT APPLY)	WORST PAIN? (√ ONE ONLY)
Head		
Neck		
Chest		
Stomach		
Back		
Arm		
Hand		
Buttocks		
Genital/Urinary		
Leg		
Knee		
Foot		

Please rate your pain by filling in the circle of the one number that best describes your pain on the average in the last week?

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine

Fill in the circle of the one number that describes how, during the past week, pain has interfered with your:

General activity

0 1 2 3 4 5 6 7 8 9 10
 Does not interfere Completely interferes

Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
 Does not interfere Completely interferes

Falling asleep

0 1 2 3 4 5 6 7 8 9 10
 Does not interfere Completely interferes

Staying asleep

0 1 2 3 4 5 6 7 8 9 10
 Does not interfere Completely interferes

Chronic pain may limit activities that are very important to you (e.g., caring for children, walking, working). We hope your pain treatment will make it easier for you to do these important activities. **Please list one important activity that is difficult for you to perform so that we can monitor it during your pain treatment.**

Activity (describe): _____

How would you rate the **difficulty** you have had **doing this activity** over the past week? Can do with...

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0	1	2	3	4	5	6	7	8	9	10
No difficulty										Extreme difficulty

Over the past 2 weeks, have you been bothered by these problems?

	Not at all	Several days	More days than not	Nearly every day
	0	1	2	3
Feeling nervous, anxious, or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Are you having any **side effects** from any of the medications you take for pain? Yes No

If yes, what is the most bothersome side effect? _____

Please circle the number that best shows the **severity of the most bothersome side effect:**

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0	1	2	3	4	5	6	7	8	9	10
None										Severe

In the past month, how many "**bad days**" have you had where you **needed to take more pain medication** than your doctor is currently prescribing?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None	1 - 2	3 - 5	> 5

Please fill in the circle of the one number that best shows how **satisfied** you are with the **results of your pain treatment:**

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0	1	2	3	4	5	6	7	8	9	10
Extremely Dissatisfied										Extremely Satisfied

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING, 0 + _____ + _____ + _____
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult
at all

Somewhat
difficult

Very
difficult

Extremely
difficult

GAD-7

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T_____ = _____ + _____ + _____)