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

To: Patients of the Vulvovaginal Specialty Clinic

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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.

UW Medicine

Women's Health Care Center
Vulvovaginal Specialty Clinic Intake

A Current Health Problem

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

- ☐ Vaginal Discharge
- ☐ Vaginal or vulvar burning
- ☐ Vaginal or vulvar itching
- ☐ Pain with sex
- ☐ 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?

- ☐ Vestibulitis
- ☐ Yeast infection
- ☐ Lichen sclerosus
- ☐ Atrophic vaginitis
- ☐ Desquamative vaginitis
- ☐ Bacterial vaginosis or "BV"
- ☐ Vulvodynia
- ☐ Lichen planus
- ☐ Vaginismus
- ☐ Other: _____

5. Can you pinpoint the exact day your symptoms started? ☐ Yes ☐ No

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

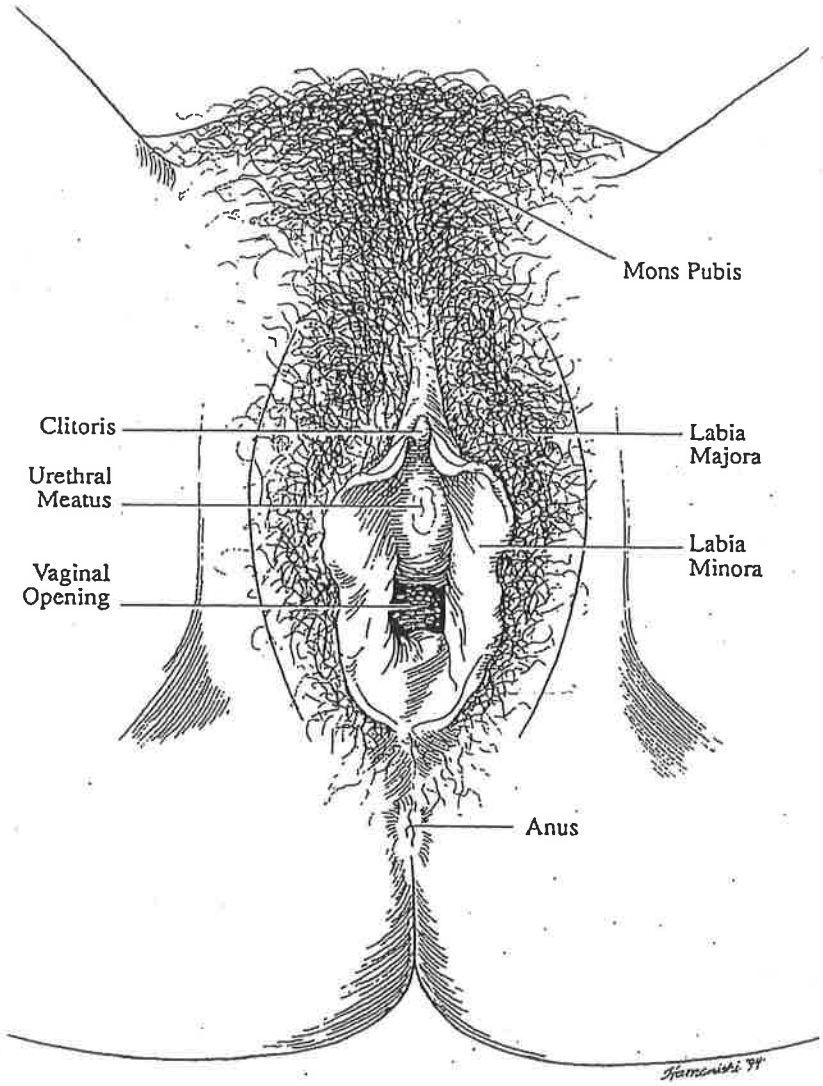
6. What makes your symptoms **worse?** _____

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



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....

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. notriptyline, 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): _____

B	Sexual Function

13. How often did you feel:

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

C	Personal and Social History

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

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

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

35. What is your employment?

- ☐ Full-time
- ☐ Part-time
- ☐ In school or vocational training
- ☐ Retired
- ☐ Homemaker
- ☐ Unemployed
- ☐ Disabled
- ☐ 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

DOB

Place ID Label Where

PainTracker™

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...

○	○	○	○	○	○	○	○	○	○	○
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	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Little interest or pleasure in doing things	○	○	○	○

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:**

○	○	○	○	○	○	○	○	○	○	○
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?

○	○	○	○
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:**

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Extremely Dissatisfied										Extremely Satisfied

PainTracker™

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 last 2 weeks, 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____ = ____ + ____ + ____)

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