A Current Health Problem

1. Please indicate which option best describes why you are visiting our clinic today:
   - [ ] Vaginal Discharge
   - [ ] Vaginal or vulvar itching
   - [ ] Vaginal or vulvar burning
   - [ ] 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
   - [ ] Bacterial vaginosis or “BV”
   - [ ] Lichen sclerosus
   - [ ] Vaginismus
   - [ ] Lichen planus
   - [ ] Atrophic vaginitis
   - [ ] 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
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. 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): ________________________________________
13. How often did you feel:

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Always</th>
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<tbody>
<tr>
<td>14. Distressed about your sex life</td>
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<td>15. Unhappy about your sexual relationship</td>
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<td>16. Guilty about sexual difficulties</td>
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<td>17. Frustrated by your sexual problems</td>
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<td>18. Stressed about sex</td>
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<td>19. Inferior because of sexual problems</td>
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<td>20. Worried about sex</td>
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<td>21. Sexually inadequate</td>
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<td>22. Regrets about your sexuality</td>
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<td>23. Embarrassed about sexual problems</td>
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<td>24. Dissatisfied with your sex life</td>
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<td>25. Angry about your sex life</td>
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<td>26. Bothered by low sexual desire</td>
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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
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
- [ ] 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

PRINTED NAME

DATE