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

5. Can you pinpoint the exact day your symptoms started? ☐ Yes ☐ No
   5a. **If yes**, what triggered the symptoms? _____

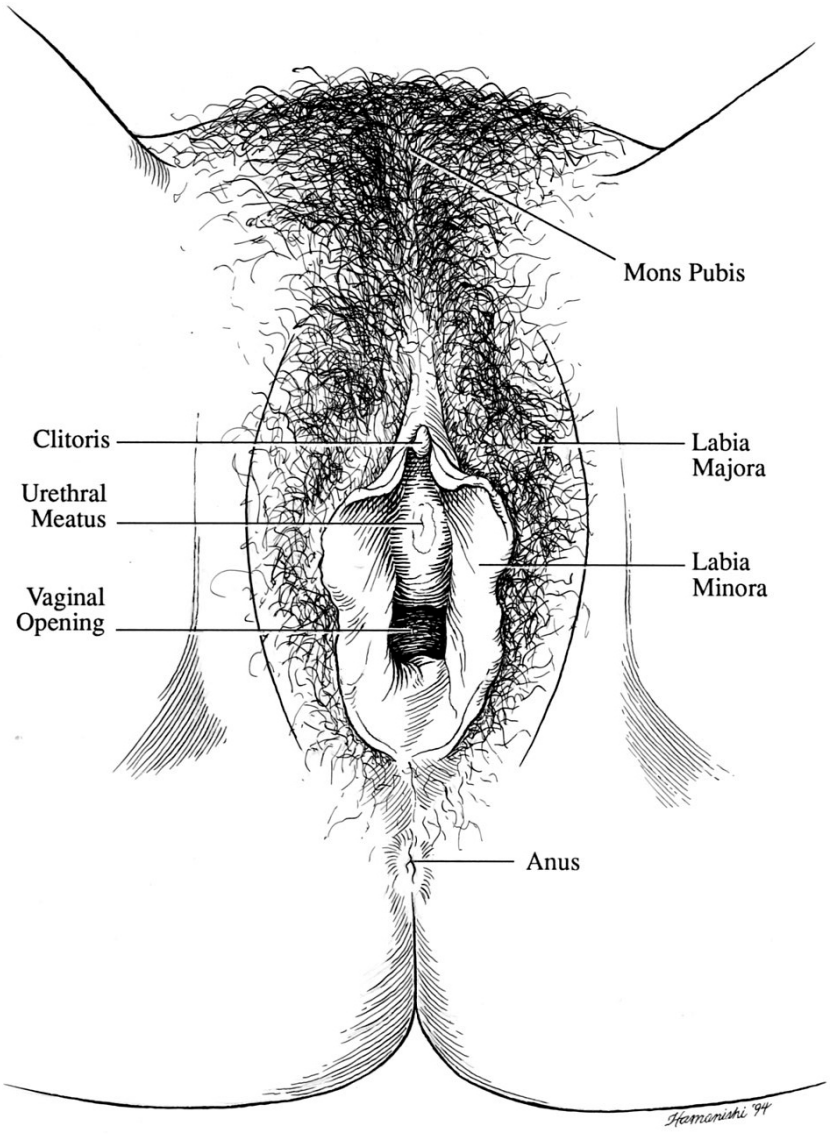
6. What makes your symptoms **worse?** _____

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

PLACE PATIENT LABEL HERE



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

PLACE PATIENT LABEL HERE

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	PRINTED NAME	DATE

PLACE PATIENT LABEL HERE