MICHIGAN MEDICINE Obstetrics and Gynecology **Vulvar Health History Questionnaire**	MRN: NAME: BIRTHDATE: CSN:

Reason for Visit and Referral Information

1. What is the reason for your visit to the Center for Vulvar Disease clinic? Please list any prior vulvar diagnosis.

_____

_____

2. Please list your previous physician(s) or health care provider(s) who have treated you for any of your vulvar symptoms?

_____

_____

_____

_____

Previous Evaluations and Treatments

1. What prescribed medications have you tried on your vulva?
   a. Oral/by mouth (name of medication, duration of treatment and dose if known): _____
   _____
   b. Topical/direct application (name of medication, duration of treatment and dose if known): _____
   _____
   c. What prescribed medication are you using currently? _____
2. What over the counter treatments have you tried on your vulva? _____
3. What are you using currently? _____
4. Have you ever had a biopsy of your vulva? ☐ Yes ☐ No
   If yes, what date and what were the results? _____
5. Have you ever had vulvar or vaginal cultures (samples)? ☐ Yes ☐ No
   If yes, what date and what were the results? _____
6. Have you ever had a vulvoscopy or colposcopy (magnification of vulva) of your vulva? ☐ Yes ☐ No
   If yes, what date and what were the results? _____
7. Have you ever had medical injections into the vulva? ☐ Yes ☐ No
   If yes, what date and what medication? _____
8. Have you ever had laser treatment for the treatment of your condition? (Including Cosmetic laser) ☐ Yes ☐ No
   If yes, what date(s)? _____
9. Have you ever had surgery on your vulva? ☐ Yes ☐ No
   If yes, what date(s) and what was the surgery? _____
10. Preventative care and gynecologic history
    a. When was your last cervical or vaginal pap test? _____
    b. Have you ever had an abnormal pap test? If so when? _____

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c. Have you ever been diagnosed with any of the following?

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Genital warts ☐ Human papilloma virus (HPV)

☐ Pelvic inflammatory disease ☐ Trichomonas ☐ Bacterial vaginosis ☐ HIV ☐ Syphilis

☐ Hepatitis B ☐ Hepatitis C ☐ Other: _____

d. Are you currently using a form of contraception/birth control or hormonal treatment for menstrual cycles?

☐ Yes ☐ No If yes: ☐ Birth control pills ☐ Intrauterine device (list type if known) _____

☐ Nexplanon (arm implant) ☐ Condoms ☐ Natural Family Planning/Rhythm ☐ Abstinence

☐ Other: _____

Vulvar Symptoms

1. Do you have any of these symptoms?

	Not at all	A little bit	Somewhat	A great deal	A very great deal
Vulvar itching	☐	☐	☐	☐	☐
Vulvar scratching	☐	☐	☐	☐	☐
Vaginal discharge	☐	☐	☐	☐	☐
Vulvar pain	☐	☐	☐	☐	☐
Vulvar sores, ulcers, fissures, cuts or tears	☐	☐	☐	☐	☐
Burning with urination	☐	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐	☐
Pelvic pain	☐	☐	☐	☐	☐
Pelvic pressure	☐	☐	☐	☐	☐
Anal pain	☐	☐	☐	☐	☐

2. When did your symptoms begin? _____

3. Frequency of your symptoms (select one):
☐ Continuous ☐ Every day ☐ Intermittent (every now and then) ☐ Only with intercourse

4. Are your vulvar symptoms brought on or made worse with the following (multiple choice):
☐ Bike rides ☐ Cold ☐ Exercise ☐ Fear ☐ Heat ☐ Hot tub ☐ Long periods of driving
☐ Masturbation ☐ Menstruation ☐ Menstrual or incontinence pads ☐ Partner touch
☐ Stress ☐ Sexual intercourse ☐ Sweating ☐ Tampon use ☐ Tight clothing ☐ Urination
☐ Walking ☐ Other (please specify): _____

5. Are your vulvar symptoms relieved by any of the following (multiple choice):
☐ Alcohol ☐ Cold/ice ☐ Distraction ☐ Douching ☐ Exercise ☐ Heat ☐ Hot tub
☐ Loose clothing ☐ Lying down ☐ No underwear ☐ Oral medication (please specify): _____
☐ Relaxation ☐ Shower ☐ Sitting ☐ Sitz bath ☐ Standing ☐ Tub bath
☐ Topical medication (please specify): _____ ☐ Other (please specify): _____

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Vulvar Health History Questionnaire

MRN:
NAME:
BIRTHDATE:
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6. What is your most comfortable position (select one): ☐ Lying down ☐ Sitting ☐ Standing
☐ Other (please specify): _____

Vulvar Pain History

1. Are you experiencing vulvar pain? ☐ Yes ☐ No (If you are not experiencing pain, please move to next section)
2. When did the vulvar pain start? _____
3. Do you recall a specific event to when your pain began? ☐ Yes ☐ No
   If yes, please specify: ☐ Injury ☐ Yeast infection ☐ Childbirth ☐ Tampon insertion
   ☐ First vaginal intercourse ☐ Other (please specify): _____
4. Please rate the intensity of your pain:
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (10 being the worst)
5. Please rate the unpleasantness of your pain:
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (10 being the worst)
6. Does the pain radiate (move to other parts of your body)? ☐ Yes ☐ No
7. Does the pain ever wake you up from sleep? ☐ Yes ☐ No

(MCGILL PAIN SCORE)
Below are 20 different groups of words. Some of the words probably describe your current pain. **Please circle ONLY those words that you believe would BEST describe your current pain. NEVER circle more than ONE word in a group. If a group has no word that describes your pain, then do not circle any word in that group.** REMEMBER: DO NOT circle more than ONE word in any group, and do not circle a word in a group if no words in that group describe your pain.

(1) Flickering Quivering Pulsing Throbbing Beating Pounding	(2) Jumping Flashing Shooting	(3) Pricking Boring Drilling Stabbing Lancinating	(4) Sharp Cutting Lacerating
(5) Pinching Pressing Gnawing Cramping Crushing	(6) Tugging Pulling Wrenching	(7) Hot Burning Scalding Searing	(8) Tingling Itchy Smarting Stinging
(9) Dull Sore Hurting Aching Heavy	(10) Tender Taut Rasping Splitting	(11) Tiring Exhausting	(12) Sickening Suffocating
(13) Fearful Frightful Terrifying	(14) Punishing Grueling Cruel Vicious Killing	(15) Wretched Blinding	(16) Annoying Troublesome Miserable Intense Unbearable
(17) Spreading Radiating Penetrating Piercing	(18) Tight Numb Drawing Squeezing Tearing	(19) Cool Cold freezing	(20) Nagging Nauseating Agonizing Dreadful Torturing
(21) Surface Deep			

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Sexual Health

1. What is your current relationship orientation?
☐ Monogamous (one partner) ☐ Polyamorous (multiple consensual partners) ☐ Other: _____

2. Are you currently in a relationship? ☐ Yes ☐ No

3. Are you currently involved in a relationship outside of your primary relationship? ☐ Yes ☐ No

4. Does your partner have pain or problems with sexual activity? ☐ Yes ☐ No

5. Do you use lubricant with sexual activity? ☐ Always ☐ Sometimes ☐ Never
If used what type? _____

Please mark any that apply to your **current** sexual activity:		☐ None ☐ Vaginal sex ☐ Masturbation ☐ Oral sex ☐ Anal sex ☐ Mutual stimulation by partner ☐ Instruments for orgasm (i.e. vibrator, sex toys)	
Quality of **current** sexual activity:		☐ Generally very satisfying ☐ Sometimes satisfactory ☐ Rarely satisfactory ☐ Never satisfactory	
Quality of sexual activity **prior to symptoms**:		☐ Generally very satisfying ☐ Sometimes satisfactory ☐ Rarely satisfactory ☐ Never satisfactory	
Frequency of sexual activity:		☐ 2 or more times per week ☐ once per week ☐ 2-3 times per month ☐ once per month ☐ less than once per month ☐ rarely ☐ never sexually active	
Are you orgasmic?		☐ Always ☐ Sometimes ☐ Very Infrequently ☐ Never	
If yes, by:	Partner stimulation	☐ Yes	☐ No
	Masturbation	☐ Yes	☐ No
	Vaginal intercourse	☐ Yes	☐ No
	Anal intercourse	☐ Yes	☐ No
	Oral sex	☐ Yes	☐ No

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Please circle the number that most closely applies to you for the following questions.

I am **interested** in sex: 1 (No interest) 2 3 4 5 (High interest)

How do you feel about yourself as a **sexual person**? 1 (Very negative) 2 3 4 5 (Very positive)

Vaginal sexual activity is important to me: 1 (Not important) 2 3 4 5 (Very important)

Have you ever experienced any unwanted sexual contact? ☐ Yes ☐ No ☐ No Answer

Does sexual activity bring up negative thoughts OR remind you of past trauma? ☐ Yes ☐ No ☐ Uncertain

Gender and Sexual Identity

1. What are your pronouns? ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ Other: _____

2. What is your current gender identity? ☐ Woman ☐ Transman ☐ Genderqueer ☐ Non-binary
☐ Additional gender category: _____

3. What is your current sexual orientation? ☐ Heterosexual ☐ Lesbian ☐ Queer ☐ Bisexual ☐ Asexual
☐ Pansexual ☐ Additional orientation category: _____

Past Medical History (Check any medical problems you have had in the past)

☐Blood transfusion

☐Cancer

☐Cardiac disease *(heart disease, angina, artery disease, heart attack, heart valve problem, heart failure, or need for a pacemaker or defibrillator)*

☐Clotting or Bleeding disorder *(excessive bleeding OR blood clots in your legs, lungs or other blood vessels)*

☐Colitis *(Diverticulitis, enteritis, Crohn's or ulcerative colitis)*

☐Diabetes mellitus

☐Gastrointestinal abnormality *(reflux, ulcers, chronic diarrhea or constipation)*

☐Headaches

☐HIV/AIDS

☐Hormone problems *(Cushing's, CAH or congenital adrenal hyperplasia)*

☐Hypertension *(high blood pressure)*

☐Liver problems

☐Neurologic disorder *(Parkinson's, multiple sclerosis, seizures, stroke, paralysis, limb weakness)*

☐Osteoporosis *(bone weakening, fractures)*

☐Physical disability *(loss of eyesight, hearing, or a birth defect)*

☐Psychiatric abnormality *(anxiety, depression needing medication)*

☐Psychological disorder *(needing counseling)*

☐Renal (Kidney) disorders *(polycystic kidney disease, kidney stones, kidney failure)*

☐Respiratory disease *(asthma, emphysema, chronic bronchitis)*

☐Rheumatoid disease

☐Substance abuse *(alcohol, prescription drugs, recreational drugs)*

☐Thyroid disease *(low or excessive thyroid hormone)*

Other medical problems: _____

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Past Surgical History (Check any surgeries you have had and the date of surgery if you know it)

☐Abdominal surgery ☐Cosmetic surgery ☐Laser conization

☐Appendectomy ☐Dilation and curettage ☐LEEP or cone biopsy

☐Breast enhancement ☐Endometrial ablation ☐Ovary removal

☐Breast surgery ☐Gastrointestinal ☐Pelvic laparoscopy

☐Cholecystectomy (gall bladder removal) ☐Gynecologic cryosurgery ☐Pelvic organ prolapse

☐Cesarean Section ☐Hysterectomy ☐Tubal ligation

☐Colposcopy ☐Hysteroscopy ☐Urinary incontinence

☐Other (list) _____

Family History *Check below to report problems your family members have had. Please state the age when they had the problem if you know it.*

☐I do not know my family history.

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Anesthesia problems							
Arthritis							
Asthma							
Breast cancer							
Cancer							
Clotting disorder							
Diabetes							
Heart disease							
Hypertension							
Migraines							
Osteoporosis							
Ovarian cancer							
Stroke							
Thyroid disease							
Other (specify)							
Alive (Yes, No or N/A=Not Applicable)							

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Gyn History:

Age when first period started: _____ years ☐Period has not yet started. *Please skip to Social History section.*

Age at first pregnancy: _____ years Age at first live birth: _____ years Months breastfeeding: _____ months

Age at menopause (no periods for 12 months in a row): _____ years *Please skip to Social History section.*

Menstrual History:

Period cycle _____ days Period duration _____ days

Period pattern: ☐Regular ☐Irregular

Menstrual flow: ☐Light ☐Moderate ☐Heavy

Menstrual control method:

☐Panty liner ☐Thin pad ☐Maxi pad ☐Hospital pad ☐Tampon ☐Other (specify) _____

How often do you change your menstrual control method? Every _____ hours.

Dysmenorrhea (painful menstruation): ☐None ☐Mild ☐Moderate ☐Severe

Obstetric History:

☐ Never pregnant ☐ Currently pregnant

Number of pregnancies (Gravida) _____ Number of deliveries (Para) _____ Number of Full Term deliveries _____

Number of Preterm deliveries (<37 weeks) _____ Miscarriages/abortions (AB) _____ Number of Living children_____

Number of Multiple birth deliveries_____

Perinatal Comments (pregnancy complications): _____

Vulvar/Vaginal Care

1. What cleansing products do you use on your vulva?

_____

_____

2. Do you use vaginal douches? ☐ Yes If yes, what type? _____

☐ No ☐ In the past, but not currently

3. What underwear do you wear most regularly, please mark all that apply:

☐ Cotton ☐ Silk ☐ Synthetic ☐ None ☐ Don't know fabric

4. What is your average frequency of showers/week? ☐ 0 ☐ 0-3 ☐ 4-7 ☐ >7

5. What is your average frequency of baths/week? ☐ 0 ☐ 0-3 ☐ 4-7 ☐ >7

Mental Health

a. Have you ever been to therapy or counseling before? ☐ Yes ☐ No

If yes, what concerns? _____

b. Have you wished you were dead or wished you could go to sleep and never wake up? ☐ Yes ☐ No

c. Have you had any thoughts about killing yourself? ☐ Yes ☐ No

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d. Have you ever been diagnosed or treated for any of these mental health problems?

Condition	Yes	No	Month & Year of diagnosis	Treatment:			Year of treatment
				Medication	Counseling	Hospitalization	
Depression							
Anxiety							
Bipolar Disorder							
Schizophrenia							
Other:							

Social History / Substance and Sexual Activity

Alcohol Use

Alcohol

Alcohol Use: ☐Yes ☐Not Currently ☐Never

How often do you have a drink containing alcohol? ☐ Never ☐Monthly or less ☐2-4 times a month

☐2-3 times a week ☐4 or more times a week ☐Refuse to answer

How many drinks containing alcohol do you have on a typical day when you are drinking?
☐1 or 2 ☐3 or 4 ☐5 or 6 ☐7 to 9 ☐10 or more ☐Refuse to answer

How often do you have six or more drinks on one occasion? ☐Never ☐Less than monthly ☐Monthly

☐Weekly ☐Daily or almost daily ☐Refuse to answer

Please indicate the quantity per week of each:

Glasses of wine: _____ Can/bottles of beer: _____ Shots of liquor: _____

Standard drinks or equivalent (contains 0.5 oz of alcohol): _____

Comments: _____

Drugs and Tobacco

Substance Use

Drug Use: ☐Yes ☐No ☐Not Currently ☐Never

What type(s) of drugs do you use? ☐Amphetamines ☐Anabolic steroids ☐Benzodiazepines ☐Cocaine

☐Fentanyl ☐Heroin ☐Hydrocodone ☐Marijuana ☐MDMA (Ecstacy) ☐Morphine ☐Oxycodone

☐Other, please list: _____

How many times per week do you use drugs? _____

Tobacco

Tobacco Use: ☐Current, every day smoker ☐Current, some day smoker ☐Former smoker

☐Never smoked ☐Exposed to second hand smoke (passive smoke exposure) – Never smoked

If you smoke or used to smoke, when did you start? State Date: _____

If you quit smoking, when did you quit? Quit Date: _____

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If you smoke or used to smoke, how many packs do or did you smoke per day?

☐0.25 ☐0.5 ☐1 ☐1.5 ☐2 ☐3

How many years did you smoke / have you smoked? ☐0.5 ☐1 ☐2 ☐3 ☐4 ☐5 ☐10 ☐15

Smokeless Tobacco: ☐Current user ☐Former user ☐Never used

What type of smokeless tobacco do or did you use? ☐Snuff ☐Chew

If you quit smokeless tobacco, when did you quit? Quite Date: _____

Are you Ready to Quit tobacco (smoking or smokeless)? ☐Yes ☐No

Would you like help quitting tobacco (smoking or smokeless)? ☐Yes ☐No

Additional Tobacco

Would you like medication substitutes for tobacco? ☐Yes ☐No

Do you use electronic smoking devices (vaping, ecig, JUUL, e-hooka)?

☐No ☐Used in the past, not presently ☐Occasionally ☐Daily

Sexual Activity

Are you Sexually Active? ☐Yes ☐Not currently ☐Never

Type of birth control / protection used (check all that you use):

☐Not having sex (abstinence) ☐Condom ☐Diaphragm ☐Injection
☐IUD (intrauterine device) ☐OCP (oral contraceptives) ☐Partner w/Vasectomy ☐Post-menopausal
☐Tubal ligation ☐Vasectomy ☐None
☐Other (specify): _____

Partner(s) (check all that apply): ☐Female ☐Male ☐ Other

Do you have a new sexual partner? ☐Yes ☐No

Social History / Lifestyle

Physical Activity

On average, how many days per week do you engage in moderate to strenuous exercise (walking fast, running, jogging, dancing, swimming, biking or other activities that cause a light or heavy sweat)?

☐0 days ☐1 day ☐2 days ☐3 days ☐4 days ☐5 days ☐6 days ☐7 days

On average, how many minutes do you engage in exercise at this level?

☐0 min ☐10 min ☐20 min ☐30 min ☐40 min ☐50 min ☐60 min

☐90 min ☐120 min ☐150+ min ☐ Refuse

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Socioeconomic

Employment

Occupation: _____

Employer: _____

Comments: _____

Demographics

Marital status: ☐Single ☐Married ☐Legally Separated ☐Divorced
☐Widowed ☐Significant Other ☐Other (specify): _____

Spouse name: _____

Number of children: _____

Years of education: _____

What is the highest level of school you have completed or the highest degree you have received?
_____

Intimate Partner Violence

1. Within the last year, have you been afraid of someone close to you?

☐ Yes ☐ No

2. Within the last year, have you been humiliated or emotionally abused in other ways by someone close to you?

☐ Yes ☐ No

3. Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by someone close to you?

☐ Yes ☐ No

4. Within the last year, have you been raped or forced to have any kind of sexual activity by someone close to you?

☐ Yes ☐ No

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Review of Systems *Please check any current problems / symptoms*

Category	Issues	No problems
Constitutional	☐activity change ☐appetite change ☐chills ☐diaphoresis (excessive sweating) ☐fatigue ☐fever ☐unexpected weight change	☐
Ears, nose, mouth, throat and face	☐facial swelling ☐neck pain ☐neck stiffness ☐ear discharge ☐hearing loss ☐ear pain ☐tinnitus (ringing in the ears) ☐nosebleeds ☐congestion ☐postnasal drip ☐rhinorrhea (nasal drainage) ☐sneezing ☐sinus pressure ☐dental problem ☐drooling ☐mouth sores ☐trouble swallowing ☐voice change	☐
Eyes	☐eye discharge ☐eye itching ☐eye pain ☐eye redness ☐photophobia (intolerance to light) ☐visual disturbance	☐
Respiratory	☐apnea (snoring) ☐chest tightness ☐choking ☐cough ☐shortness of breath ☐stridor (noisy high-pitched breathing) ☐wheezing	☐
Cardiovascular	☐chest pain ☐leg swelling ☐palpitations (racing heart beats)	☐
Gastrointestinal	☐abdominal distention ☐abdominal pain ☐anal bleeding ☐blood in stool ☐constipation ☐diarrhea ☐nausea ☐rectal pain ☐vomiting	☐
Genitourinary	☐difficulty urinating ☐dyspareunia (painful sexual intercourse) ☐dysuria (painful urination) ☐enuresis (leaking urine when asleep) ☐flank pain ☐urinary frequency ☐genital sore ☐blood in urine ☐urinary urgency ☐decreased urine ☐menstrual problem ☐pelvic pain ☐vaginal bleeding ☐vaginal discharge ☐vaginal pain	☐
Musculoskeletal	☐joint pain ☐back pain ☐gait problem ☐joint swelling ☐myalgias	☐
Skin	☐color change ☐pallor ☐rash ☐wound	☐
Neurologic	☐dizziness ☐facial asymmetry ☐headaches ☐light-headedness ☐numbness ☐seizures ☐speech difficulty ☐fainting ☐tremors ☐weakness	☐
Hematologic (blood)	☐adenopathy (large or swollen lymph nodes) ☐bleeds/bruises easily	☐
Behavioral / Psychological	☐agitation ☐behavior problem ☐confusion ☐decreased concentration ☐severe premenstrual symptoms ☐hallucinations ☐hyperactive ☐nervous / anxious ☐self-injury ☐sleep disturbance ☐suicidal thoughts	☐

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