SECTION 1: REASON FOR VISIT

Which of the following doctors have you seen for this problem?

☐ Family Doctor	☐ Walk-in Clinic Doctor	☐ Gynaecologist
☐ Dermatologist	☐ Urologist	☐ Other:

Have you been given a diagnosis?	☐ Yes	☐ No
Do you agree with the diagnosis?	☐ Yes	☐ No

Briefly describe the reason for your visit today?

SECTION 2: VULVAR SYMPTOMS

Which of the following vulvar symptoms apply to you at this time? Check all that apply. If you do NOT have symptoms Go to SECTION 3

☐ Itch	☐ Urge to scratch	☐ Burning
☐ Soreness, rawness	☐ Stabbing, pinching	☐ Dryness
☐ Numbness	☐ Sexual discomfort	☐ Unable to have sexual intercourse/penetration

In general how would you rate your symptoms **over the last 4 weeks**?

☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Very Severe

How long have you had symptoms? months years

Where are your symptoms located? Check all that apply

☐ Mons – above the pubic bone	☐ Hair bearing large lips of vulva	☐ Hairless inner lips of vulva	☐ Entrance to vagina
☐ Inside of vagina	☐ Around the anus	☐ Buttocks	☐ Other

Do your symptoms spread to other areas?	☐ Yes	☐ No

Are your symptoms – check all that apply?

☐ Constant	☐ Come and go daily	☐ Come and go weekly/monthly	☐ Cyclic – relative to the menstrual cycle

Since your symptoms began have your symptoms?

☐ Improved	☐ Worsened	☐ Stayed the same	☐ Went away completely and then came back again

Are there any factors that make your symptoms better?	☐ Yes	☐ No
Are there any factors that make your symptoms worse?	☐ Yes	☐ No

Do your symptoms interfere with – (check all that apply)

☐ Clothing choices	☐ Exercise	☐ Sitting
☐ Caring for children	☐ Household chores	☐ Sleep
☐ Employment	☐ Walking	☐ Sexual activity

SECTION 3: GENITAL SIGNS

Have you noticed any of the following changes **over the last 4 weeks**?
Check all that apply or check **NONE**

☐ Abnormal vaginal bleeding	☐ Erosions (raw areas)	☐ Ulcers
☐ Abnormal vaginal discharge	☐ Rash	☐ Vulvar discharge
☐ Bleeding after vaginal intercourse	☐ Rectal bleeding	☐ Vulvar swelling
☐ Blisters	☐ Red areas of skin	☐ Vulvar bleeding
☐ Brown/black areas of skin	☐ Sores, cuts or raw areas	☐ White areas of the skin
☐ Bumps	☐ Splitting of skin	☐ **NONE**

Are there any other changes to the genital skin that you have noticed?

☐ Yes DESCRIBE:	☐ No

Have you had a vulvar skin biopsy – when by whom what was the result?

☐ Yes - When? Result?	☐ No

SECTION 4: GENITAL HYGEINE

How often do you wash the vulva?	# per times per day

Do you remove your pubic hair?	☐ Yes	☐ No
Please check all of the following that you use in the genital area –		
☐ Bar soap ☐ Barrier cream ☐ Bubble bath, bath oils or salts ☐ Feminine hygiene sprays ☐ Lubricants ☐ Incontinence pads	☐ Menstrual cups ☐ Menstrual pads ☐ Oils ☐ Perfumes ☐ Lubricants ☐ Powders ☐ Skin cleansers	☐ Shaving cream ☐ Tampons ☐ Vaginal douches ☐ Wash cloths to clean ☐ Washes or toilettes ☐ Wax ☐ Other not listed

SECTION 5: GYNAECOLOGICAL HISTORY

PAST GYNECOLGICAL INFECTION: Check any that apply or check **NONE**

☐ Bacterial Vaginosis	☐ Genital warts	☐ Pelvic Inflammatory Disease
☐ Chlamydia	☐ Gonorrhea	☐ Syphilis
☐ Frequent bladder infections	☐ Herpes – genital	☐ Other:
☐ Frequent yeast infections	☐ HIV/AIDS	☐ **NONE**

Have you ever been pregnant?	☐ Yes	☐ No
Do you have menstrual periods?	☐ Yes	☐ No
Are your periods regular?	☐ Yes	☐ No
Do you have bleeding or spotting between periods?	☐ Yes	☐ No
Are you currently using birth control?	☐ Yes	☐ No
Have you been vaccinated against HPV?	☐ Yes	☐ No
Have you had any abnormal pap smears?	☐ Yes	☐ No
Have you ever been diagnosed with a pre-cancer lesion of the vulva, vagina and or cervix?	☐ Yes	No
I you have stopped menstruating at what age did your period's stop?	Age?	
Have you ever been on hormone replacement therapy?	☐ Yes	☐ No
Are you currently on HRT?	☐ Yes	☐ No

Are you currently sexually active?	☐ Yes	☐ No

DERMATOLOGY LIFE QUALITY INDEX

	Very much	A lot	A little	Not at all	Not relevant
Over the last week, how itchy, sore, painful or stinging has your skin been?	☐	☐	☐	☐	☐
Over the last week, how embarrassed or self conscious have you been because of your skin?	☐	☐	☐	☐	☐
Over the last week, how much as your skin interfered with you going shopping or looking after your home or garden?	☐	☐	☐	☐	☐
Over the last week, how much as your skin influenced the clothes you wear?	☐	☐	☐	☐	☐
Over the last week, how much as your skin affected any social or leisure activities	☐	☐	☐	☐	☐
Over the last week, how much as your skin made it difficult to do any sport?	☐	☐	☐	☐	☐
Over the last week has your skin prevented you from working or studying?	☐	☐	☐	☐	☐
Over the last week, how much as your skin created problems with your partner or any of your closer friends or relative?	☐	☐	☐	☐	☐
Over the last week, how much as your skin caused any sexual difficulties?	☐	☐	☐	☐	☐
Over the last week, how much of a problem has the treatment for your skin been? For example, my making your home messy or taking up time?	☐	☐	☐	☐	☐

Please check you have answered EVERY question. Thank you. ©AY Finlay, GK Khan, April 1992 www.dermatology.org.uk, this must not be copied without the permission of the authors.

SECTION 6 PAST MEDICAL HISTORY: Check any that apply or check **NONE**

☐ Alcoholism	☐ Heart disease	☐ Lung disease
☐ Arthritis	☐ High blood pressure	☐ Mental Illness
☐ Autoimmune disease	☐ Heartburn, ulcer	☐ Nerve condition
☐ Blood clot lungs/legs	☐ Hepatitis	☐ Osteoporosis
☐ Cancer	☐ Headaches (migraine, tension)	☐ Past blood transfusions
☐ Diabetes	☐ Interstitial cystitis	☐ Thyroid disease
☐ Drug abuse/addiction	☐ Irritable bowel	☐ Stroke
☐ Endometriosis	☐ Kidney disease	☐ **NONE**
☐ Fibromyalgia/Chronic Fatigue Syndrome	☐ Liver disease	☐ OTHER

Please describe OTHER Medical Problems:

SECTION 7 PAST SURGICAL HISTORY: Check any that apply or check NONE

☐ Appendix	☐ Gallbladder	☐ Laparoscopy
☐ Bladder surgery	☐ Heart surgery	☐ Ovarian surgery
☐ Bowel surgery	☐ Hip surgery	☐ Tubal ligation
☐ Breast surgery	☐ Hysterectomy	☐ Vaginal surgery
☐ Caesarean section	☐ Hysteroscopy	☐ Vulvar surgery
☐ D& C	☐ Infertility surgery	☐ **NONE**
☐ Eisiotomy repair	☐ Knee surgery	☐ OTHER

Please describe OTHER Surgery:

SECTION 8 MEDICATIONS AND ALLERGIES

Current Medications	Allergies
☐ None	☐ None
☐ Yes, If so please list below	☐ Yes, If so please list below

Thank you for taking the time to complete this questionnaire