Patient Name/identification number:_____

ISSVD Vulvodynia Pattern Questionnaire

Purpose:
To better separate vestibulodynia (vulvar vestibulitis syndrome) from generalized vulvodynia (dysesthetic vulvodynia, essential) and identify additional previously recognized and unrecognized patterns and factors

Demographics:

1) *Age* _____ *Date of birth* _____

2) *Country of birth* _____

3) *Race (circle one)* African background Hispanic/Latin White

Asian/Pacific Islander/Native American

4) *Marital status (circle one)* single married divorced

widowed significant other

5) *Educational level*
(circle highest level attended) high school college/trade school

graduate school

Or, years of education 1-8 8-12 above 12

6) *Profession* _____

6) *Estrogen status (circle one)* premenopausal

postmenopausal, no hormone replacement

postmenopausal, hormone replacement by mouth or patch

postmenopausal, vaginal hormone cream

8) *At about what age did you experience menopause?* _____

9) *Was your menopause (circle one)* natural following removal of ovaries

10) *Number of previous pregnancies* _____

11) *Date of last pregnancy* _____

12) *Abortions/miscarriages (number)* _____

13) *Have you breastfed a child in the past 8 months?* yes no

Symptoms

1) *What are your symptoms? (circle all that apply)*

burning	stinging	rawness	irritation
soreness	itching	stabbing	knife-like
paper-cuts	aching		
other	_____		
	_____		

All symptoms will be referred to as "pain" in this questionnaire, even though your own symptoms may not be pain, but rather burning, irritation, rawness, etc.

2) *Date these symptoms first began (if different symptoms began at different times, please indicate the date of onset of each symptom)*

_____

_____

_____

3) *If you have pain with intercourse, how long following your first intercourse did this begin?* _____

4) *Have you* **ever** *experienced comfortable intercourse? (circle one)* yes no

4) *Did something happen to start your pain, such as a vaginal infection, surgery, delivery of a baby, etc? (circle one)*

yes no

If yes, what was this?

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5) *Location of pain (indicate on drawing on last page)*

6) *Does touching the area or pressure to the area cause pain?*

yes no sometimes

7) *Is there pain only when the area is touched?*

yes no

8) *Which of the following produces pain?*

Sexual intercourse yes no

If yes,

With penetration yes no

During intercourse yes no

After intercourse yes no

With all partners yes no

Insertion of tampon yes no

Tight clothing or blue jeans yes no

Riding a bicycle or horse yes no

Urination yes no

In the absence of intercourse yes no

8) *Which of the following produces pain (Continued)?*

Urination

Only following intercourse yes no

Other

*(describe)*_____
_____
_____
_____

9) *Do you ever have pain/burning/irritation/rawness/soreness when nothing is touching the area and you have not recently had sexual intercourse?*

Yes No

10) *Are your symptoms worse (circle all that apply)* before your period

during your period after your period between periods

no relation to periods not applicable/not having periods

Other Problems

1) *Do you have constipation?* Yes No

2) *Do you have diarrhea?* Never Occasionally (more than 3 times a year)

Often Always/Usually

3) *Do you have problems with:*

Burning or stinging with urination? Never Sometimes

Often Always/Usually

Difficulty starting your stream? Never Sometimes

Often Always/Usually

Other Problems (Continued)

Leaking urine?	Never	Sometimes
	Often	Always/Usually
Sudden need to urinate immediately	Never	Sometimes
	Often	Always/Usually

4) *Which of the following problems do you have? (circle)*

Fibromyalgia	High blood pressure
Frequent headaches	Angina pectoris/heart attacks
Frequent urinary tract infections	Diabetes mellitus
Chronic fatigue syndrome	Genital herpes
Low energy levels	Thyroid disease
Depression	Sinus problems/hay fever
Difficulty sleeping	Allergies to medications
Weight gain or loss of more than ten pounds unintentionally in the past six months	
Back pain	TMJ syndrome (temporomandibular joint)
Pelvic pain	

5) *Have you had an abnormal Pap smear? (circle one)* yes no

If yes, please write what your understanding of the diagnosis and how you were treated

6) *What do you use for birth control? (circle all that apply)*

Birth control pills	condoms with spermacide
diaphragm with spermacides	condoms alone
intrauterine device (IUD)	surgical (tubes tied, hysterectomy)
no birth control	
other	

7) *How long have you used each of these methods of birth control*

Previous Treatment

Please circle any types of medications you have used, and circle your response to that medication

Type of Therapy	*The therapy made me*	
Creams or suppositories for yeast infections	Worse/burned	Little change
	Much Better	
Medication by mouth for yeast infections	Worse	Little change
	Much Better	
Cream or ointment antibiotic for bacterial infection	Worse/burned	Little change
	Much Better	
Antibiotic by mouth for bacterial infections	Worse	Little change
	Much Better	
Cortisone or steroid creams or ointments	Worse/burned	Little change
	Much Better	

Cortisones, prednisone, or steroid by mouth	Worse	Little change
	Much Better	
Estrogen cream	Worse/burned	Little Change
	Much Better	
Testosterone cream or ointment	Worse/burned	Little change
	Much Better	
Tricyclic medications (amitriptyline, desipramine, and imipramine) If yes, what medication, what dose did you reach, and how long did you take it?		
_____	Worse	Little change
	Much Better	
_____	Worse	Little change
	Much Better	
_____	Worse	Little change
	Much Better	
Other antidepressant medications (if yes, what medication, what dose did you take, and how long did you take it?)		
_____	Worse	Little change
	Much Better	
_____	Worse	Little change
	Much Better	
_____	Worse	Little change
	Much Better	
Twelve local interferon injections	Worse	Little change
	Much Better	

Narcotic pain medications, such as codeine, hydrocodone, oxycodone, morphine, methadone)

Worse Little change

Much Better

Soaks (Aveeno, Burrow's Domeborrows) Worse/burned Little change

Much Better

Moisturizers (Replens, KY Jelly, Vaseline) Worse/burned Little change

Much Better

Gabapentin (Neurontin) Worse Little change

Much Better

Add dose and length of treatment

_____

Effexor (venlafaxine) Worse Little change

Much Better

Add dose and length of treatment

_____

Lamictil Worse Little change

Much Better

Add dose and length of treatment

_____

Topical anesthetics, such as Xylocaine (lidocaine) or pramoxine Worse/burned Little change

Much Better

Calcium oxalate alone Worse/burned Little change

*Add length of treatment*_____

Much Better

Low oxalate diet with calcium oxalate Worse/burned Little change

Much Better

Add dose and length of treatment

_____

Other medications (please list, including dose and length of treatment)

_____ Worse/burned Little change Much Better

_____ Worse/burned Little change Much Better

_____ Worse/burned Little change Much Better

_____ Worse/burned Little change Much Better

_____ Worse/burned Little change Much Better

_____ Worse/burned Little change Much Better

Pelvic floor rehabilatation/biofeedback Worse Little change Much Better

Vestibulectomy Worse/burned Little change Much Better Cured

Other surgery (list, then circle response)

_____

_____

Worse/burned Little Change Much Better Cured

What is your height? _____ Weight? _____

Physical examination

1) Height _____

2) Weight _____

3) *Erythema present (indicate location on map?* Normal/mild Moderate Severe

4) *Other abnormalities, including erosions, agglutination, pigment changes*

_____

_____

_____

_____

_____

5) *Area of pain as indicated by patient (indicate on map)*

6) *Pain to pressure with cotton-tipped applicator (indicate on map)*

For each area indicate mild, moderate or severe

7) *Appearance of vaginal mucosa (circle one)*

Normal

Erythema mild moderate severe patchy

Erosions few/small moderate/medium size

large/extensive

Atrophic (pale, smooth, dry) slight moderate marked

8) *Vaginal secretion appearance (circle one)*

Normal/white/creamy green/yellow

white,"cottage cheese" blood/menses

none/scant

9) *Vaginal secretion quantity (circle one)* decreased average

increased

10) *Vaginal pH* _____

11) *Microscopic appearance of vaginal secretions (check one)*

	normal or absent	[slight	*increased* moderate	marked]
Lymphocytes	_____	_____	_____	_____
Neutrophils	_____	_____	_____	_____
Yeast hyphae	_____	_____	_____	_____
Pseudohyphae	_____	_____	_____	_____
Budding yeast only	_____	_____	_____	_____
Trichomonads	_____	_____	_____	_____
Clue cells	_____	_____	_____	_____
Immature epithelial cells	_____	_____	_____	_____
Latobacilli	_____	_____	_____	_____