

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?

- 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)

| | | |
|---|-------|----------------|
| <i>Leaking urine?</i> | Never | Sometimes |
| | Often | Always/Usually |
| <i>Sudden need to urinate immediately</i> | 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 spermicide

diaphragm with spermicides

condoms alone

intrauterine device (IUD)
no birth control

surgical (tubes tied, hysterectomy)

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

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

| | | |
|---|--------------|---------------|
| <i>Narcotic pain medications, such as codeine, hydrocodone, oxycodone, morphine, methadone)</i> | Worse | Little change |
| | Much Better | |
| <i>Soaks (Aveeno, Burrow's Domeborrows)</i> | Worse/burned | Little change |
| | Much Better | |
| <i>Moisturizers (Replens, KY Jelly, Vaseline)</i> | Worse/burned | Little change |
| | Much Better | |
| <i>Gabapentin (Neurontin)</i> | Worse | Little change |
| | Much Better | |
| <i>Add dose and length of treatment</i> | | |
| <hr/> | | |
| <i>Effexor (venlafaxine)</i> | Worse | Little change |
| | Much Better | |
| <i>Add dose and length of treatment</i> | | |
| <hr/> | | |
| <i>Lamictil</i> | Worse | Little change |
| | Much Better | |
| <i>Add dose and length of treatment</i> | | |
| <hr/> | | |
| <i>Topical anesthetics, such as Xylocaine (lidocaine) or pramoxine</i> | Worse/burned | Little change |
| | Much Better | |
| <i>Calcium oxalate alone</i> <i>Add length of treatment</i> _____ | Worse/burned | Little change |
| | Much Better | |
| <i>Low oxalate diet with calcium oxalate</i> | Worse/burned | Little change |
| | Much Better | |
| <i>Add dose and length of treatment</i> | | |
| <hr/> | | |

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 | |
| <i>Pelvic floor rehabilitation/biofeedback</i> | Worse | Little change |
| | Much Better | |
| <i>Vestibulectomy</i> | 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 | <i>increased</i> moderate | marked] |
|----------------------------------|------------------|---------|------------------------------|---------|
| <i>Lymphocytes</i> | _____ | _____ | _____ | _____ |
| <i>Neutrophils</i> | _____ | _____ | _____ | _____ |
| <i>Yeast hyphae</i> | _____ | _____ | _____ | _____ |
| <i>Pseudohyphae</i> | _____ | _____ | _____ | _____ |
| <i>Budding yeast only</i> | _____ | _____ | _____ | _____ |
| <i>Trichomonads</i> | _____ | _____ | _____ | _____ |
| <i>Clue cells</i> | _____ | _____ | _____ | _____ |
| <i>Immature epithelial cells</i> | _____ | _____ | _____ | _____ |
| <i>Lactobacilli</i> | _____ | _____ | _____ | _____ |