Vulvar Pain
(Please respond to every question)

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ E-mail: _____

Who referred you to see Dr. Kinney?_____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Please list all current medications that you take or apply to your skin, including birth control. (List additional medications on the back of this page, if needed.)

MEDICATION	DOSAGE	PURPOSE

Please list all allergies or medication intolerances. Write additional allergies on the back of this page if needed.

ALLERGY	REACTION

What is your vaginal/vulvar diagnosis, if it is known? _____

When did the problem for which you are seeing Dr. Kinney first begin? _____

What are your vaginal/vulvar symptoms (itching, burning, rawness, pain with sexual activity, etc.)? Please give us as much detail as possible. (Use the back of this page if necessary.)

_____
_____
_____
_____
_____
_____

If you are itchy, is this an itch that makes you want to rub and scratch? **YES** **NO**

If you rub or scratch, does it feel good at first? **YES** **NO**

Has it been a constant problem? **YES** **NO** Does it "come and go"? **YES** **NO**

Do you ever have pain/burning/rawness or soreness when nothing is touching or recently has touched the area? **YES** **NO**

Have you noticed anything that worsens this problem? ____ **YES** ____ **NO** If yes, what?

_____
_____

Do your symptoms interfere with your sleep? ____ **YES** ____ **NO**

If you are sexually active, do you have pain with intercourse or sexual activities? **YES** **NO**

Have you ever experienced comfortable sexual activity? **YES** **NO**

Please list all treatments, both prescription and non-prescription, that you have used for this problem. (Please do not say "see my records".) You may need to call your pharmacy for names of medications. You can use the back of this page if needed.

List of treatments/medications	Better	Worse	No Change

What are you using right now on your genital skin for washing, lubrication, treatment or for any other reason? Please list **any** soaps, douches, vaginal washes, powders, moisturizers, colognes, sprays, creams, ointments, etc.

_____

_____

How often do you wash this area? _____

If you have periods, do you use: Tampons _____ Pads _____

Do you use panty liners? **YES NO**

Has anyone in your family had chronic genital pain, burning, rawness or itching as far as you know? **YES NO** If yes, who and what? _____

Have you had a vulvar biopsy? (A piece of skin removed from your genital area and sent to a laboratory). **YES* NO**

What year? _____ Physician's Name: _____

Physician's Phone Number: _____

* If yes, please request from the ordering physician that the biopsy report be sent to our office.

Please list all surgeries	Year Done

Have you had any of the following?	Yes	No
Abnormal Pap Smear (If yes, when and what was done?)		
Genital Warts		
Genital Herpes		
Shingles (If yes, where on your body?)		
Diabetes		
Eczema		
Psoriasis		
Allergic Rhinitis		
Asthma		
Chronic Sinus Problems		

Have you ever been in the hospital for reasons other than surgery or childbirth? **YES NO**
If yes, for what reason? _____

When was your most recent pregnancy? _____

Have you breast-fed a child in the past eight months? **YES NO**
If yes, when did you stop? _____

Have you been through menopause? **YES NO Year** _____

Circle if you have any problems with the following:

General: energy levels depression anxiety sleep issues headaches

Gastrointestinal: constipation diarrhea heartburn difficulty swallowing

Bladder: urinary frequency burning leakage urgency

Mouth: pain sores

Eyes: dryness pain stinging

Musculoskeletal: back pain joint pain

Have you ever been diagnosed with (circle please): irritable bowel syndrome

fibromyalgia interstitial cystitis chronic fatigue syndrome pelvic pain

temporomandibular joint disorder other pain syndrome _____

Do you have any other medical illnesses we have not included? **YES NO** (If yes please list).

_____

_____

What do **you** think may be causing the problem?

_____

_____

_____

Do you have any fears or worries concerning this problem? **YES NO** If yes, what are they?

_____

_____

_____

Have you ever considered committing suicide over this condition? **YES NO**

Is there anything else you feel that we should know? **YES NO** If yes, what?

_____

_____

_____

_____

Preferred Pharmacy Name and Phone#_____

For office use

Provider's Signature: _____

Cheryl Cox Kinney, M.D. FACOG, NCMP

Last revised: 7/16/2022