Vulvar Diseases Dermatology Clinic
Carly Kirshen, MD, FRCPC
Civic Hospital Parkdale Clinic
737 Parkdale Ave
Ottawa, ON, K1Y 4E9
Phone: 613-761-4689
Fax: 613-761-4087

PATIENT INFORMATION PACKET

(Please respond to every question)

Name ____

Address____

City _________________Province ________Postal Code ________

Telephone____________________E-mail____________________

Date of Birth: ____________________Today's Date__________________

May we leave a message on your voicemail? circle Yes No

Who referred you to see Dr. Kirshen? ________________________

Physician's Address____

City _________________Province _________Postal Code ___________

Telephone _______________Fax ________________

Please Check: **For research purposes only**

Race		Education	
Race	1.______Native Canadian	Education	1.____Grade school
	2. ______Asian		2. ____Completed high school
	3. ______Black/African Canadian		3.____College
	4. ______White		4. ____University degree
	5. ______Middle Eastern		5.____Post-graduate degree
	6. ______Other		
	7. ______More than one race		

Marital Status	1._______Single 2._______Married 3. _______Separated 4._______Divorced 5._______Widowed	Occupation	1.____Work outside the home 2.____Homemaker 3. ____Retired 4.____Disabled 5.____Unemployed
Household Income	1._____0-10 000 2._____10 000 – 30 000 3. _____30 000 – 50 000 4. _____50 000 – 100 000 5. ____>100 000		

If you work outside the home, what is your occupation?

____

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)

MEDICATION	DOSAGE	PURPOSE

Please list all allergies or medication intolerances, and write additional allergies on the back of this page

ALLERGY	REACTION

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

____

When did the problem for which you are seeing Dr. Kirshen first begin?__________________

Do you recall any specific incident that occurred when your symptoms first began? If yes, what?

____

What are your vaginal/vulvar symptoms (itching, burning, rawness, pain with sexual activity, etc.)? Please give 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 (all day)? **Yes** **No** Does it "come and go"? **Yes** **No**

Is it present only with intercourse? **Yes** **No** Does it wake you up from sleep? **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 in particular 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**

Rate the Intensity of your symptom on a scale from 0 (none) to 10 (worst) __________________

Please list all treatments, both prescription and non-prescription, that you have used for this problem. (Please do not say "see my records") You can 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

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 ____________________

Have you had a vulvar culture? (A swab) **Yes*** **No**

What Year:______________________ Physician's name:____________________

Physician's phone number ____________________

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

____

____

How often do you wash this area? ___________________________________

Do you use vaginal douches? **Yes** **No**

If you have periods, do you use: Do you use panty liners? **Yes** **No**

Tampons_____________ Brand _____________

Pads ______________ Brand _____________

Below is a list of gynecologic problems. Please indicate those problems for you have been diagnosed.

	Yes		Yes		Yes
Yeast infections		Trichomonas		HPV (warts)	
Bacterial vaginosis		Syphilis		Pelvic inflammatory Disease	
Chlamydia		Frequent UTIs		AIDS/HIV	
Herpes		Chronic vaginal discharge			

If you have ever had a yeast infection: please answer the following:

Age at first yeast Infection____________ Number of yeast infections per year_____________

Most recent yeast infection_____________

Treatments for yeast: creams supportories oral medication

Please list all surgeries	Year it was done

Have you ever had any of the following?	**Yes**	**No**
Abnormal Pap Smear (if yes, when and what was done)		
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? __________

Were your delivery(ies) vaginal? ____________Forceps? ____________
Vacuum? ____________C-section____________

Have you had any abortions? ____________ Miscarriages? ____________

Have you had any treatment for infertility? If yes, what? ____________________________________

Do you plan on becoming pregnant in the future? ____________

Have you breast-fed a child in the past twelve months? **Yes** **No**
If yes, when did you stop? _______________

Do you use contraception (birth control) currently? What method? ________________________

Have you ever used contraception? What method(s) ____________________________________

____

Do you have menstrual periods? **Yes** **No**

If you do not have periods, please indicate the reason:

Menopause, if yes age: _______________

Surgical removal of both ovaries, if yes year _______________

Hormonal medications _______________________________

If you still have your periods, how many days between periods? _______________

Duration of periods (how many days do they last) _______________

Circle if you have any problems with the following:

General: energy levels depression anxiety sleep headaches

High blood pressure chest pain irregular heart beat

Thyroid problems Kidney problems Liver problems Cancer

Gastrointestinal: constipation diarrhea heartburn difficulty swallowing

Ulcerative colitis Crohn's

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): irritable bowel syndrome fibromyalgia

interstitial cystitis chronic fatigue syndrome temporomandibular joint disorder

pelvic pain other pain syndrome_________________

Condition	Yes	No	Year of diagnosis	Medication?	Counseling	Hospital	Year of Treatment
Depression							
Anxiety							
Bipolar							
Schizophrenia							
Other:							

Do you have any other medical illnesses we have not included? **Yes** **No** (If yes please list)____

____

What do **<u>you</u>** 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**

Do you smoke cigarettes? **Yes** **No** **Past** **Packs per day**_______________**#Years**__________

Do you drink alcohol? **Yes** **No** **Past** **Drinks per week** ____________________

Do you smoke marijuana? **Yes** **No** **Past**

Do you exercise? **Yes** **No** **Past** Hours per week: ____________________

<u>Sexual History (all information will be kept confidential)</u>

Have you ever been sexually active? **Yes** **No**

If yes, please answer the following questions:
Have you been sexually active in the last 6 months **Yes** **No**
Age at first intercourse ____________________
Number of lifetime sexual partners (approximate) ____________________

Number of partners since vulvar symptoms began? ____________________

Current relationship status ____

How would you describe your sexuality? (sex with men/women/both)_______________________

Do you use lubricants with sexual activity? If yes, which type? ____________________

Please mark any that apply to your current sexual activity:
None ________________ Vaginal sex ________________ Masturbation ____________________
Oral sex ______________ Anal sex ______________ Instruments (sex toy etc) _________________

Quality of current sexual activity:
Very satisfying __________________ Sometimes satisfying _____________________
Rarely satisfying ________________ Never satisfying _____________________

Quality of Sexual activity prior to symptoms:
Very satisfying __________________ Sometimes satisfying _____________________
Rarely satisfying ________________ Never satisfying _____________________

Frequency of sexual activity:
2+/week ________________ 1/week ________________ 2-3/month ________________
<1/month ________________ rare ________________ Never ________________

Have you ever experienced sexual abuse? ____

Have you ever experienced physical abuse? ____

Is there anything else you feel that we should know? **Yes** **No** If yes, what?
____
____
____
____

For office use

Provider's Signature: ____

Carly Kirshen, MD

Please Remember:

1) This is a clinic at a teaching hospital and you will be seen by residents. The residents may be female or male.
2) Photographs will be taken at your visit.
3) Once your condition is under control, you will be transferred back to your referring physician for further monitoring (if needed)

Tips for Vulvar Skin Care

While you are seeking treatment from us for your problem, here are some coping measures that might relieve symptoms and prevent further irritation. These irritants are not *causing* your symptoms, but they could be making them worse. As a woman with a history of vulvar symptoms, you should try these guidelines to prevent flares--even when you are feeling well. After your symptoms are under control, you can restart any habits that are important to you.

- Wash the vulva no more often than once a day, using water only; do not use a washcloth, but only soft finger tips.
- Avoid soap, douches, powders, over-the-counter medications (especially Vagisil or benzocaine/polysporin) on this area.
- If any prescribed topical medications produce burning, stop using them and call your provider
- Do not use panty liners, especially the brand "Always." If you have to use panty liners, Glad Rags may be less irritating, and can be ordered from gladrags.com
- With periods, use tampons rather than pads if possible. Consider Knix underwear
- Prevent constipation by adding fiber to your diet; an easy solution is one or two large helpings of a very high fiber cereal such as All Bran or All Bran Extra, with large amounts of fluid. Laxatives may be needed.
- Apply ice, frozen peas or a frozen blue gel pack (lunch box size) wrapped in a hand towel to relieve burning. But, be careful not to overdo, since frostbite is a real possibility.
- Use a lubricant with sexual activity. Women with vaginal symptoms tend to be dry. Astroglide, Slippery Stuff, or sunflower oil (not K-Y) are good choices for a lubricant.
- Try applying topical anesthetic (Xylocaine, lidocaine – NOT Vagisil) 30 minutes before sexual activity if sexual activity is painful for you.
- Contraceptive creams or spermicides, and latex condoms can be irritating.

Let us know of any tips you have learned that we can pass on to our other patients!