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 not applicable/not having periods
other 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?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Often</td>
<td>Always/Usually</td>
</tr>
</tbody>
</table>

Sudden need to urinate immediately

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

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)
- 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

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>The therapy made me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creams or suppositories for yeast infections</td>
<td>Worse/burned</td>
</tr>
<tr>
<td></td>
<td>Little change</td>
</tr>
<tr>
<td></td>
<td>Much Better</td>
</tr>
<tr>
<td>Medication by mouth for yeast infections</td>
<td>Worse</td>
</tr>
<tr>
<td></td>
<td>Little change</td>
</tr>
<tr>
<td></td>
<td>Much Better</td>
</tr>
<tr>
<td>Cream or ointment antibiotic for bacterial infection</td>
<td>Worse/burned</td>
</tr>
<tr>
<td></td>
<td>Little change</td>
</tr>
<tr>
<td></td>
<td>Much Better</td>
</tr>
<tr>
<td>Antibiotic by mouth for bacterial infections</td>
<td>Worse</td>
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<tr>
<td></td>
<td>Little change</td>
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<tr>
<td></td>
<td>Much Better</td>
</tr>
<tr>
<td>Cortisone or steroid creams or ointments</td>
<td>Worse/burned</td>
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<tr>
<td></td>
<td>Little change</td>
</tr>
<tr>
<td></td>
<td>Much Better</td>
</tr>
<tr>
<td>Medication</td>
<td>Worse</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Cortisones, prednisone, or steroid by mouth</td>
<td></td>
</tr>
<tr>
<td>Estrogen cream</td>
<td>Worse/burned</td>
</tr>
<tr>
<td>Testosterone cream or ointment</td>
<td>Worse/burned</td>
</tr>
<tr>
<td>Tricyclic medications (amitriptyline, desipramine, and imipramine)</td>
<td></td>
</tr>
<tr>
<td>If yes, what medication, what dose did you reach, and how long did you take it?</td>
<td></td>
</tr>
<tr>
<td>Tricyclic medications (amitriptyline, desipramine, and imipramine)</td>
<td>Worse</td>
</tr>
<tr>
<td>Tricyclic medications (amitriptyline, desipramine, and imipramine)</td>
<td>Worse</td>
</tr>
<tr>
<td>Tricyclic medications (amitriptyline, desipramine, and imipramine)</td>
<td>Worse</td>
</tr>
<tr>
<td>Other antidepressant medications (if yes, what medication, what dose did you take, and how long did you take it?)</td>
<td>Worse</td>
</tr>
<tr>
<td>Other antidepressant medications (if yes, what medication, what dose did you take, and how long did you take it?)</td>
<td>Worse</td>
</tr>
<tr>
<td>Twelve local interferon injections</td>
<td>Worse</td>
</tr>
<tr>
<td>Twelve local interferon injections</td>
<td>Worse</td>
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</table>
### Narcotic pain medications, such as codeine, hydrocodone, oxycodone, morphine, methadone

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<thead>
<tr>
<th></th>
<th>Worse</th>
<th>Little change</th>
<th>Much Better</th>
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### Soaks (Aveeno, Burrow’s Domeborrows)

<table>
<thead>
<tr>
<th></th>
<th>Worse/burned</th>
<th>Little change</th>
<th>Much Better</th>
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</table>

### Moisturizers (Replens, KY Jelly, Vaseline)

<table>
<thead>
<tr>
<th></th>
<th>Worse/burned</th>
<th>Little change</th>
<th>Much Better</th>
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</thead>
</table>

### Gabapentin (Neurontin)

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<tr>
<th></th>
<th>Worse</th>
<th>Little change</th>
<th>Much Better</th>
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</table>

**Add dose and length of treatment**

### Effexor (venlafaxine)

<table>
<thead>
<tr>
<th></th>
<th>Worse</th>
<th>Little change</th>
<th>Much Better</th>
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</table>

**Add dose and length of treatment**

### Lamictil

<table>
<thead>
<tr>
<th></th>
<th>Worse</th>
<th>Little change</th>
<th>Much Better</th>
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</table>

**Add dose and length of treatment**

### Topical anesthetics, such as Xylocaine (lidocaine) or pramoxine

<table>
<thead>
<tr>
<th></th>
<th>Worse/burned</th>
<th>Little change</th>
<th>Much Better</th>
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</thead>
</table>

### Calcium oxalate alone

**Add length of treatment**

<table>
<thead>
<tr>
<th></th>
<th>Worse/burned</th>
<th>Little change</th>
<th>Much Better</th>
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</table>

### Low oxalate diet with calcium oxalate

<table>
<thead>
<tr>
<th></th>
<th>Worse/burned</th>
<th>Little change</th>
<th>Much Better</th>
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</table>

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

____________________________________Worse/burned Little change

____________________________________Worse/burned Little change

____________________________________Worse/burned Little change

____________________________________Worse/burned Little change

____________________________________Worse/burned Little change

____________________________________Worse/burned Little change

Pelvic floor rehabilitation/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)**

<table>
<thead>
<tr>
<th></th>
<th>normal or absent</th>
<th>slight</th>
<th>moderate</th>
<th>marked</th>
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<tbody>
<tr>
<td><strong>Lymphocytes</strong></td>
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<td></td>
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</tr>
<tr>
<td><strong>Neutrophils</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Yeast hyphae</strong></td>
<td></td>
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<tr>
<td><strong>Pseudohyphae</strong></td>
<td></td>
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<tr>
<td><strong>Budding yeast only</strong></td>
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<tr>
<td><strong>Trichomonads</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Clue cells</strong></td>
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<tr>
<td><strong>Immature epithelial cells</strong></td>
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</tr>
<tr>
<td><strong>Latobacilli</strong></td>
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