

## VULVAL PAIN QUESTIONNAIRE

### YOUR BACKGROUND

Name

.....

Age

.....

Date of birth

.....

Number of children

.....

Were these vaginal deliveries or caesarean sections?

.....

If appropriate, did these deliveries affect your vulval symptoms?

No *Go to next question*

Yes *Give details*

.....

.....

.....

Have you had any gynaecological problems in the past?

No *Go to next question*

Yes *Give details*

.....

Any other health problems?

.....

.....

.....

.....

.....

.....

**GENERAL LIFESTYLE**

What is your present work or occupation?

.....

Do you do any physical fitness activities?

- No *Go to next question*
  
- Yes *Please list what, and how often*

.....

.....

.....

**PRESENT VULVAL COMPLAINTS**

What diagnosis do you have for your symptoms?

.....

**Please indicate the type of symptoms that you have (you can indicate one or more)**

- Burning       Soreness       Irritation       Itching       Painful sex
- Vaginal discharge     Other, please state \_\_\_\_\_

**Are your symptoms constant?**

- Yes       No       Intermittent – good days and bad days

**What bothers you the most about your problem?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**How many months/years have you had symptoms?**

\_\_\_\_\_

\_\_\_\_\_

**How is your general energy level?**

\_\_\_\_\_

\_\_\_\_\_

**What do you clean the vulval area with? How often do you wash/clean your vulva?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have your doctors prescribed or recommended any medications?**

No *Go to next question*

Yes *Please give the names of all substances that you can remember (including vaginal preparations, skin creams and pills)*

.....

.....

.....

**Have you put anything not prescribed by a doctor on your skin yourself for treatment?**

No *Go to next question*

Yes *Please list*

\_\_\_\_\_

.....

.....

**Can you remember what exactly caused your symptoms?**

No *Go to next question*

Yes *Please list*

\_\_\_\_\_

.....

.....

**How are the symptoms you now have related to your initial symptoms?**

Same

Less intense discomfort

More intense discomfort

- Less frequent     More frequent

**Have you been free of symptoms at any time? For how long?**

No    *Go to next question*

Yes    *When?*

.....

.....

.....

**Are there certain times of the day when your symptoms are more noticeable?**

- Morning             Evening             Night (bedtime)     Always throughout the day
- With urination     After a bowel movement

**Are there certain times of the month when your symptoms are more noticeable?**

- Worse just before my menstrual period             Worse during my menstrual period             Worse just after my menstrual period
- Always the same during the month             Worse when I ovulate (mid-cycle)

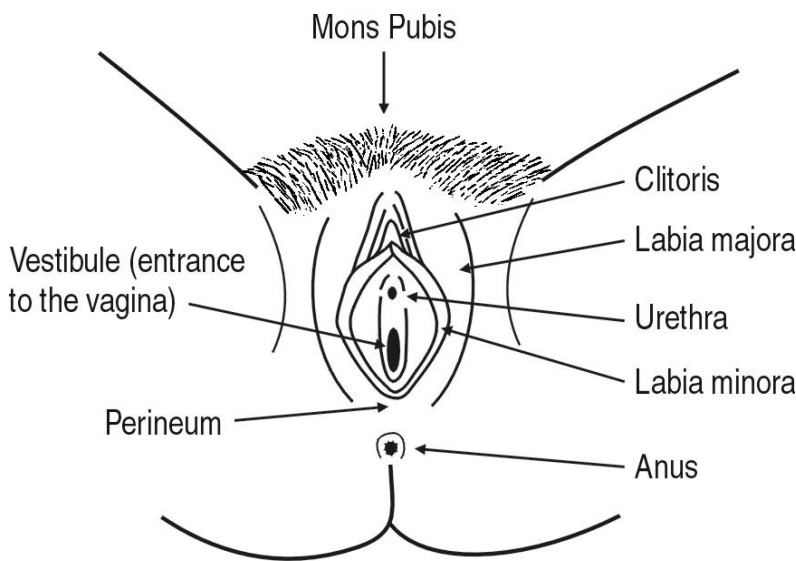
**The statement which describes the discomfort which I most often have:**

- Slight, I notice only when I think about it
- Slight, I can ignore it by not thinking about it
- Moderate, I always know it's there but I can still perform most tasks
- Severe, it allows me to perform only tasks which require little concentration
- Severe, makes it impossible for me to do anything but seek medical attention

Please mark the squares which best show the location of your symptoms (a diagram and description of the different parts of the vulva are provided below for information)

- |  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Mons pubis area           | <input type="checkbox"/> Clitoris                 | <input type="checkbox"/> Labia majora                  | <input type="checkbox"/> Labia minora |
| <input type="checkbox"/> Urethra (bladder opening) | <input type="checkbox"/> Vestibule (inside vulva) | <input type="checkbox"/> Vagina (within the vestibule) | <input type="checkbox"/> Perineum     |
| <input type="checkbox"/> Anal area                 |   |  |                                       |

*Diagram showing the different parts of the vulva*



*Explanation of the diagram*

This is a black and white line diagram of the vulva. The vulva is viewed from the front, looking between the legs, with the woman lying on her back and the vulva spread open to show its inner parts.

Working from top to bottom of the diagram, so from the front to the back of the body, and from the outside inwards, the parts of the vulva shown are as follows:

**Mons pubis** - the hairy, fatty triangular pad on the front of the body, just above the vulva

**Labia majora** - the hairy, fatty outer lips containing the inner vulva

**Labia minora** - the hairless, fatless inner lips inside and between the labia majora

**Clitoris** - a pea-sized organ located at the top meeting point of the labia minora below the mons pubis

**Urethra** - the opening used to pass urine, located between the labia minora, below the clitoris and above the vaginal opening

**Vestibule** - the entrance to the vagina, located between the labia minora around the vaginal opening

**Perineum** - the bridge of skin and muscle located at the bottom meeting point of the labia majora, between the vaginal opening and the anus

**Anus** - the external opening to the bowel, located below and behind the perineum towards the back.

### **My discomfort usually causes**

- NO interference with daily routine or planned activities
- SOME interference with daily routine or planned activities
- An interruption in daily routine or planned activities
- Confinement to bed
- The pursuit of immediate medical attention

### **Are you currently in a relationship?**

- Yes
- No

### **My symptoms**

- Do not affect sexual intercourse for me
- Sometimes prevent me from sexual intercourse
- Completely prevent me from sexual intercourse
- Cause discomfort, but do not prevent sexual intercourse
- May or may not affect sexual intercourse, but I don't know, as I am not sexually active

**When/if my symptoms prevent sexual intercourse, we**

- Avoid sexual intimacy altogether
  - Are physically close, but avoid sexual contact
  - Concentrate on my partner's satisfaction
  - Have relations as usual
  - Other: \_\_\_\_\_
- 

**Is your partner aware of your problems?**

- No *Go to next question*
  - Yes *If yes, what is the reaction?* \_\_\_\_\_
- 
- 

**Have you ever ended a relationship due to your vulval symptoms?**

- No
- Yes

**Have you thought that your vulval symptoms might be related to:**

- |         |                              |                             |            |                              |                             |
|---------|------------------------------|-----------------------------|------------|------------------------------|-----------------------------|
| Injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer?    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stress? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Infection? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thrush? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |            |                              |                             |

Other possible causes? \_\_\_\_\_



.....  
**Do you think that there are any factors in your diet that might aggravate your symptoms?**

No *Go to next question*

Yes *Please list*

\_\_\_\_\_

.....  
**Have you had any problems with your back (current symptoms or past history)?**

No *Go to next question*

Yes *Please describe*

\_\_\_\_\_

.....  
**Are you optimistic about the future?**

Yes, my pain will go at some stage     Yes, I will learn to live with the pain     No

**Is there anything else you'd like to say about your vulval pain?**

.....

\_\_\_\_\_

\_\_\_\_\_

.....