QUESTIONNAIRE FOR NEW PATIENTS ATTENDING JOINT VULVAL CLINIC

This questionnaire has been designed to make your first consultation with the doctors in the Joint Vulval Clinic more effective and beneficial for you. **PLEASE COMPLETE IT AND BRING IT ALONG WITH YOU WHEN YOU ATTEND FOR YOUR APPOINTMENT.**
Your answers are CONFIDENTIAL and will be kept within your clinical notes. *Your email address will not be given to any other person or passed on to a third party.*

NAME: ..... **HOSPITAL NO:**..... .....
TELEPHONE NO:..... **E MAIL:** .....

1. *Who has referred you to this clinic?*

General practitioner
Hospital doctor
e.g. Gynaecologist, Dept. of Sexual health
Other*(specify)* .....

2a. *What is your occupation?* .....
b. *How many children do you have?*.....
c. *Are you: single; married; cohabiting; divorced; widowed?*

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3. *How long have you had this problem with your vulva?*

1-6 months 6-12 months 1-5 years More than 5 years

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4. *What is your main complaint or symptom?*

Itching Soreness Burning A lump or swelling

Vaginal discharge Other *(specify)* .....

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5. *What problems does your vulval condition give you?*

Disturbed sleep Bleeding or discharge Depression/feeling low
Difficulty using tampons Difficulty with sexual intercourse Pain on walking/sitting
Other *(specify)* .....

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6. *What treatments have you had for your condition?*

'Thrush' treatment(s) Antibiotics Vaginal pessaries Steroid creams *(specify)*

Other *(specify)* .....

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7. *What do you think may make your condition worse?*

Sitting/walking Stress Toiletries/cosmetics Tampons

Sexual intercourse Menstruation Other *(specify)* .....

8. *Have you had any other problems with the skin on the rest of your body (including scalp)?*

Eczema
Psoriasis
Other *(specify)*
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9. *What other medical or surgical problems have you had?*

Medical problems:
e.g. Diabetes

Surgical problems:
e.g. Hysterectomy, Hip replacement

10a. *What medication are you taking?*
b. *Do you have any allergies?*
c. *When did you last have a cervical smear?*
d. *What was the result?*

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11. *Have you ever smoked?* Yes/No *Do you smoke now?* Yes/No

How many cigarettes each day do you currently smoke? 1 – 10; 10-20; more than 20/day

How much alcohol each week do you drink? None; 5-10 units; 10-20 units; More than 20 units/week

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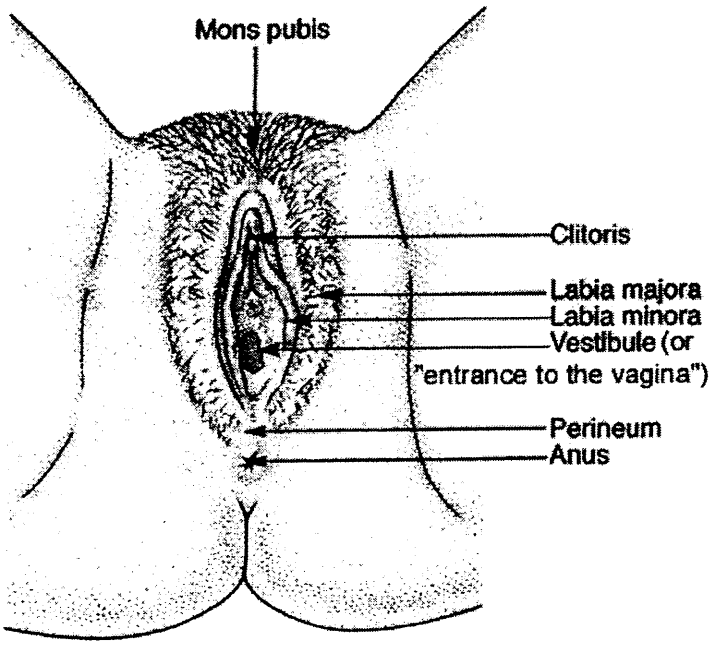

Please draw on this diagram to indicate where you have the problem on your skin.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. REMEMBER TO BRING IT WITH YOU WHEN YOU ATTEND FOR YOUR APPOINTMENT. YOUR ANSWERS WILL HELP US DECIDE UPON THE RIGHT TREATMENT FOR YOU.

Whipps Cross University Hospital NHS Trust
Dr. Karen Gibbon
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