**Chronic Vaginitis Patients Only – *Please only fill out this page if you have chronic vaginal discharge, itching, burning and irritation.***

How long have you had symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you associate with the onset of symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use pads/pantyliners other than during menses? Yes / No

Are you menopausal? Yes / No

If yes, have you used hormone therapy? Yes / No

Do you have any of the following? (check all that apply and describe)

|  |  |  |
| --- | --- | --- |
| **Check one** | **Symptom** | **Please describe (include length of time)** |
| * Yes / No
 | Vaginal itching |  |
| * Yes / No
 | Vulvar itching |  |
| * Yes / No
 | Vulvar irritation |  |
| * Yes / No
 | Vulvar burning |  |
| * Yes / No
 | Vulvar rawness |  |
| * Yes / No
 | Pain with intercourse | 🞎 Initial Entry 🞎 Deep inside 🞎 Both |
| * Yes / No
 | Leaking or urine requiring pad padpad |  |
| * Yes / No
 | Vaginal discharge |  |
| * Yes / No
 | Skin sensitivity |  |
| * Yes / No
 | Have you experienced pain or discomfort in the genital area for 3 months or longer? |
| * Yes / No
 | Have you ever experienced burning in your genital area that persisted for 3 months or longer? |
| * Yes / No
 | Have you ever experienced periodic knife-like or sharp pain in your genital area that persisted longer than 3 months? |
| * Yes / No
 | Have you ever experienced excessive pain on contact to your genital area? For example, upon insertion of a tampon, at time of intercourse, during pelvic examination or when clothing touches the area? |

Do you have recurrent yeast infections? Yes / No – Number per year

If yes, how is the yeast infection diagnosed? \_

How many times per day do you wash your vulva?

# Previous Treatments

**Treatments for vaginitis: (*please only complete the following section if you have vaginal discharge or itching)***

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Treatment *(please specify)*** | **Duration** | **Amount of Benefit** |
|  | Monistat (miconazole) |  | * None Some Good Worsened
 |
|  | Terazol (terconazole) |  | * None Some Good Worsened
 |
|  | Diflucan(fluconazole) |  | * None Some Good Worsened
 |
|  | Sporonox (Itraconazole) |  | * None Some Good Worsened
 |
|  | Other antifungal |  | * None Some Good Worsened
 |
|  | Hydrocortisone |  | * None Some Good Worsened
 |
|  | Clobetasol |  | * None Some Good Worsened
 |
|  | Mycolog (Triamcinolone and Nystatin) |  | * None Some Good Worsened
 |
|  | Steroid Injection |  | * None Some Good Worsened
 |
|  | Estrogen cream |  | * None Some Good Worsened
 |
|  | Progesterone cream |  | * None Some Good Worsened
 |
|  | Testosterone cream/ointment |  | * None Some Good Worsened
 |
|  | Lidocaine ointment |  | * None Some Good Worsened
 |
|  | Flagyl (metronidazole) |  | * None Some Good Worsened
 |
|  | Metrogel |  | * None Some Good Worsened
 |
|  | Probiotics (Yeast Arrest, FemDophilus) |  | * None Some Good Worsened
 |
|  | Other over-the-counter treatment |  | * None Some Good Worsened
 |
|  | Naturopathy |  | * None Some Good Worsened
 |

**Please check the following products that you use and list brands:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Product** | **Specify Brand(s)** | **Frequency of use** |
|  | Bath soap (specify bar/body wash) |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | Shampoo/Conditioner |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | Laundry detergent |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | Fabric softener |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | Dryer sheets |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | Bleach |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | OxyClean |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | Feminine wash |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | Feminine wipes |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | Douche |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | Swimming pool |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | Hot tubs |  | * Rarely
 | * Occasionally
 | * Frequently
 |
|  | Bubble baths |  | * Rarely
 | * Occasionally
 | * Frequently
 |

|  |
| --- |
| Bladder Function |
| *Do you experience any of the following? (check all that apply and describe)*  |
| Check one | **Symptom** |  |
| 🞎 Yes / 🞎 No | Loss of urine with coughing, sneezing, or laughing |  |
| 🞎 Yes / 🞎 No | Frequent urination | Number of voids Daytime: 🞎 8 or less 🞎 9 – 15 🞎 >16 |
| 🞎 Yes / 🞎 No | Need to urinate with little warning | Number of voids Nighttime: 🞎 0🞎 1 🞎 2-3 🞎>=4 |
| 🞎 Yes / 🞎 No | Frequent bladder infections |  |
| 🞎 Yes / 🞎 No | Feeling the need to void even after urination |  |

|  |
| --- |
| Bowel Function |
|  How often do you have a bowel movement? |
| * < 1 week 2-3 times a week Daily 1-2 times daily more than 3 times a day
 |
|  Do you ever involuntarily lose stool or gas?  |
| * Yes / No How often?
 |