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**Please take a few minutes to answer the following questions prior to your appointment with Dr. Po. You will have the chance to clarify any of the questions once you meet with the doctor. This will hopefully make your appointment more efficient and focused.**

**VULVAR CLINIC**

**Name:**

**Date of Birth**:

1. When was the first day of your last period?

2. Have you been pregnant in the past? [ ] Yes [ ] No

 **If Yes, answer the following:**

 How many total pregnancies have you had?

How did you deliver: vaginal deliveries or C-Sections?

3. Are you planning on having any future pregnancies? [ ] Yes [ ] No [ ] Not sure

4. Do you have any medical conditions or previous admissions to the hospital? Please list.

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5 Have you had any surgeries in the past? Please list and indicate the year the surgery was done.

6 Are you taking any regular medications, including birth control? **[ ]** Yes [ ] No

 **If Yes, please list:**

7. Do you have allergies to medications or latex? **[ ]** Yes [ ] No

 **If Yes, please list:**

8. Do you have a family history of cancer or medical conditions? [ ] Yes [ ] No

**If Yes, please provide details:**

9. Do you smoke cigarettes? [ ] Yes [ ] No **If yes,** how many per day?

10. Do you use cannabis? [ ] Yes [ ] No

11. How many glasses of alcohol do you drink in one week?

12. Do you use recreational drugs? [ ] Yes [ ] No **If Yes,** what and how much per week?

13. Are you currently in a relationship? [ ] Yes [ ] No Are you currently sexually active? [ ] Yes [ ] No

14. What do you do for work?

15. When was your last pap test done?

16. Have you had any abnormal pap tests? [ ] Yes [ ] No

**If Yes**, what and when?

17. Have you ever been treated for a sexually transmitted infection? [ ] Yes [ ] No

**If Yes**, what and when?

18. Do you have vulvar pain? [ ] Yes [ ] No

When did it start? Month       Year

Do you recall any specific incident that occurred when your pain first began? [ ] Yes [ ] No

**If Yes**, please describe event:

Are your symptoms:

 [ ] Intermittent (every now and then)

[ ] Every day

[ ] Only with intercourse

Describe your pain or discomfort:

What makes your pain or discomfort worse?

What makes your pain or discomfort better?

19. Vulvar Pain. Do you experience the following:

1. Vulvar itching? [ ] None at all [ ] Some [ ] All the time
2. Vulvar scratching? [ ] None at all [ ] Some [ ] All the time
3. Vaginal discharge? [ ] None at all [ ] Some [ ] All the time
4. Vulvar sores or cuts? [ ] None at all [ ] Some [ ] All the time

20. Have you had any previous treatments? [ ] Yes [ ] No

 If yes, please describe treatments (ex: surgery, injections, creams, oral medications):

21. Vulvar Hygiene. Do you use vaginal douches? [ ] Yes [ ] No

 Do you use vaginal cleansing products? [ ] Yes [ ] No

 What fabric of underwear do you use? [ ] Cotton [ ] Silk. [ ] Synthetic [ ] None. [ ] Don’t know

 How many times week do you shower?

 How many times week do you take a bath?

 What soaps do you use?

 On your period, do you use: [ ] tampon [ ] pads [ ] Diva cup

22. Do you have pain with urination? [ ] Yes [ ] No

 Do you have pain with bowel movements? [ ] Yes [ ] No

***Thank you for completing this form!***