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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!***