Cahaba Dermatology
skin health center
Vlada Groysman, MD, FAAD
2290 Valleydale Road Ste 204, Hoover AL 35244

Phone: 205.214.7546, www.cahabaderm.com

Referring Physician _____

Address: _____

Phone: _____ Fax: _____

Requirements before your appointment:

- **All records from previous physicians participating in your current condition must be received by the time of your appointment.**
- **All paperwork must be filled out before your appointment**
- **No topical medication should be applied 3 days before your visit with Dr. Groysman**
- **Please Do Not Bring your children to your visit. You may bring your partner on the second visit.**
- **$250 No show fee will be applied to your account if you No Show for your visit, cancel or reschedule your appointment with less than 24 hrs notice.**

Vulvar Mucosal Specialty Clinic – Patient Questionnaire

PLEASE PROVIDE FULL LEGAL NAME. PLEASE NOTE: PRESCRIPTIONS WILL BE CALLED IN UNDER YOUR LEGAL NAME

1. What is your vulvar diagnosis (if known)? _____
2. What is the main symptom for which you are coming to the Vulvar Mucosal Specialty Clinic? _____
   _____
3. What areas of your body are affected? (Circle all that apply)
   Vulva / Vagina Perianal Area Buttocks Mouth

Other skin (please list): _____

4. Are your vulvar symptoms generalized or localize?
   - ☐ Generalized (over the entire vulvar area)
   - ☐ Localized (in one or more specific areas)

5. When did your vulvar problem first begin (month/year)? _____

6. Is your problem constant?
   - ☐ No ☐ Yes

7. Does your problem come and go?
   - ☐ No ☐ Yes

8. Do you have times when you are FREE of vulvar symptoms?
   - ☐ No ☐ Yes

9. In general, how would you rate your vulvar symptoms?
   - ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

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10. Does your problem interfere with your sleep?

☐ No ☐ Yes

11. Is there anything in particular that makes your problem worse? _____

12. Is there anything in particular that makes your problem better? _____

13. Have you been seen and treated by another health care provider for this condition?

Dermatologist ☐ No ☐ Yes

Name: _____

Office address: _____

Office phone: _____

Office fax: _____

Family practitioner ☐ No ☐ Yes

Name: _____

Office address: _____

Office phone: _____

Office fax: _____

Gynecologist ☐ No ☐ Yes

Name: _____

Office address: _____

Office phone: _____

Office fax: _____

Internist ☐ No ☐ Yes

Name: _____

Office address: _____

Office phone: _____

Office fax: _____

Neurologist ☐ No ☐ Yes

Name: _____

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Office address: _____

Office phone: _____

Office fax: _____

Physical therapist ☐ No ☐ Yes

Name: _____

Office address: _____

Office phone: _____

Office fax: _____

Psychiatrist ☐ No ☐ Yes

Name: _____

Office address: _____

Office phone: _____

Office fax: _____

Urologist ☐ No ☐ Yes

Name: _____

Office address: _____

Office phone: _____

Office fax: _____

Other ☐ No ☐ Yes

Name: _____

Office address: _____

Office phone: _____

Office fax: _____

14. Have you had a vulvar biopsy?

☐ No ☐ Yes

Date of biopsy: _____

Name of doctor that performed biopsy: _____

Diagnosis from biopsy (if known): _____

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15. Please list the medications that you have used (both over-the-counter and prescription) to treat this condition:

Name of Medication	Date of use (month/year	Impact on Problem (better, worse, no change)

16. What do you think may have caused your vulvar condition? _____

_____

17. What are your fears concerning this problem? _____

_____

18. Have you noticed a change in:

Your vaginal discharge	□ No	□ Yes	Describe _____
Amount	□ No	□ Yes	Describe _____
Consistency	□ No	□ Yes	Describe _____
Color	□ No	□ Yes	Describe _____
Odor	□ No	□ Yes	Describe _____
Bloody discharge	□ No	□ Yes	Describe _____

19. How often do you cleanse your genital are?

_____Number of times per day

_____Number of times per week

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20. What products do you use on your genital area? (List specific brand names for all products)

Soaps (liquid or bar, brand)	Powders	Deodorants	Douches	Perfumes	Moisturizers/lotions	Other

21. Do you have menstrual periods?

□ No □ Yes

22. Are your menstrual periods regular?

□ No □ Yes

23. What was the date of your last menstrual period (month/date/year)? _____

24. If you are post-menopausal, at what age did you experience menopause? _____

25. Have you ever been on hormone replacement therapy?

□ No □ Yes If yes please list medication and dates of use: _____

_____

26. Do you use panty liners?

□ No □ Yes If yes, please list brand and whether scented or unscented: _____

_____

27. Do you use tampons?

□ No □ Yes If yes, please list brand and whether scented or unscented: _____

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28. Do you use sanitary napkins (pads)?

□ No □ Yes If yes, please list brand and whether scented or unscented: _____

29. Have you ever been pregnant?

□ No □ Yes

Number of total pregnancies: _____

Number or premature births: _____

Number of miscarriages/abortions: _____

Number of live births: _____

Number of vaginal births: _____

Number of cesarean sections: _____

30. Are you sexually active?

□ No □ Yes

31. Do you use birth control/contraception?

□ No □ Yes

32. Do you use any of the following?

Condom	□ No	□ Yes	Implant	□ No	□ Yes
IUD	□ No	□ Yes	Partner vasectomy	□ No	□ Yes
Tubes tied	□ No	□ Yes	Patch	□ No	□ Yes
Birth control pills	□ No	□ Yes	Hormone shot	□ No	□ Yes
Vaginal ring	□ No	□ Yes	Diaphragm	□ No	□ Yes

33. Do you use lubricant during sexual activity?

□ No □ Yes Name of lubricant: _____

34. How many sexual partners have you had during the past 3 months? _____

During the past year? _____ During the past 5 years? _____

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35. Do you have pain/discomfort with sexual activity?

□ No □ Yes

36. How has this condition affected your sex life? _____

_____

_____

_____

37. In general, how is your health?

□ POOR □ FAIR □ GOOD □ VERY GOOD □ EXCELLENT

38. Please list all medical problems that you have: _____

_____

_____

_____

39. Have you ever been diagnosed with any of the following conditions?

Abnormal Pap smear	□ No	□ Yes	**Psoriasis**	□ No	□ Yes
Genital warts	□ No	□ Yes	**Lichen planus**	□ No	□ Yes
Sexually transmitted disease	□ No	□ Yes	**Vitiligo**	□ No	□ Yes
Tubal infection	□ No	□ Yes	**Back injury**	□ No	□ Yes
HIV infection	□ No	□ Yes	**Back pain**	□ No	□ Yes
Frequent urinary tract infections	□ No	□ Yes	**Neuro disorder**	□ No	□ Yes
Frequent vaginal yeast infections	□ No	□ Yes	**Depression**	□ No	□ Yes
Interstitial cystitis	□ No	□ Yes	**Anxiety**	□ No	□ Yes
Endometriosis	□ No	□ Yes			
Irritable bowel syndrome	□ No	□ Yes			
Anal fissures	□ No	□ Yes			
Fibromyalgia	□ No	□ Yes			
Chronic fatigue syndrome	□ No	□ Yes			
Diabetes	□ No	□ Yes			
Thyroid disease	□ No	□ Yes			
Autoimmune disease	□ No	□ Yes			
Hay fever/allergies	□ No	□ Yes			

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Asthma □ **No** □ **Yes**

Eczema □ **No** □ **Yes**

40. Please list all surgeries that you have had: _____

_____

41. Please list all of your current medications (over-the counter and prescription, including hormones, birth control and herbal or other nutritional products) and the reason for use.

Name of Medication	Reason for Use

42. Are you allergic to any medications?

□ No □ Yes If yes, how state which one and what type of allergy do you have?

_____ _____

43. Please list any medical problems that occur in your family: _____

_____

44. What is your marital status?

□ Single □ Married □ Divorced □ Widowed

45. What is your occupation? _____

46. Do you drink alcohol?

□ No □ Yes If yes, how many drinks per week do you have? _____

_____

47. Do you smoke?

□ No □ Yes If yes, how many cigarettes per week do you have? _____

_____

_____