

QUESTIONNAIRE

Behavioural Medicine Institute of Australia

Demographic Data

Name: _____

Date: _____

Age: _____

DOB _____

Primary Physician: _____

Address: _____

Telephone Number: _____

Treating Specialist: _____

Address: _____

Telephone Number: _____

Notes:

Please respond to all relevant questions by writing an answer in the space provided by placing a check mark in the appropriate box or circling the correct score on a scale of 1 to 10.

1. Current Marital Status:

- Single
- Married How long? _____
- Separated How long? _____
- Living with significant other How long? _____
- In a relationship but living separately How long? _____

2. If single, are you:

- Widowed
- Divorced
- Never married
- In a relationship

3. Number of children: _____

General Health History

4. At what age did you start menstrual periods?

- 8 - 10 years of age
- 10 - 13 years of age
- 13 - 16 years of age
- 16 years of age

5. Are your periods generally

- regular
- irregular

OR if you are middle aged
check one of the following:

- premenstrual
- menstrual
- post menstrual
- HRT Yes

No

6. Periods usually come about every _____ days,

and last for _____ days

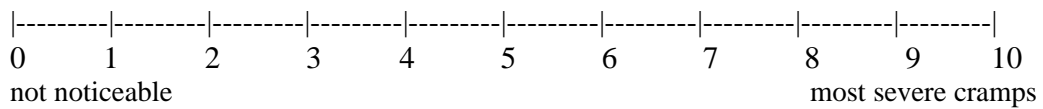
7. Heaviest flow requires

- _____ number of pads/day
- _____ number of tampons/day

8. Do you have pain/severe cramps during periods?

- Never
- Sometimes
- Always

How do you rate the severity of the cramps?



9. Do you suffer from any of the following pre-menstrual syndrome symptoms?

- Breast tenderness
- Generalised swelling
- Mood changes
- Abdominal pain and or bloating
- Muscle Tension
- Tiredness
- Changes in sexual desire _____ increase _____ decrease
- Cramps and pain _____
- Other, please specify _____

10. Do you have bleeding between periods?

- No
- Yes, please describe the extent of the bleeding, _____

11. Do you currently use a method of birth control?

- No
- Yes, please specify _____

12. Other birth control methods used in the past.

- Condoms used for a period of _____
- Oral contraceptives for a period of _____
- Intrauterine device (IUD) for a period of _____
- Other, please specify _____
For what period of time have you used these? _____

13. Have you ever been pregnant?

- No (If no please proceed to Question 20)
- Yes

14. How many children have you given birth to through:

Vaginal delivery _____
Caesarean section _____

15. Were there medical complications during any of the births?

- No
- Yes, please describe the complications _____

16. Did you have any of the following?:

- Epidural
- Episiotomy
- Extensive tearing
- None of the above

17. Have you ever had a miscarriage?

- No
- Yes, please provide further information

18. Have you ever had a termination of pregnancy (therapeutic or otherwise?)

- No
- Yes, how long ago? _____

19. Were there any complications with the miscarriage or termination of pregnancy?

- No
- Yes Please describe these complications _____

20. Have you undergone any other surgical procedures, eg. gynaecological or non-gynaecological?

- No

- Yes
Please list: _____

21. Have you ever been medically diagnosed with thrush?

- No
- Yes

If yes please specify

- Occasional
- Frequent
- Chronic

Specify types of treatments prescribed and used _____

Was this diagnosis confirmed by swab tests ?

- No
- Yes

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

- Endometriosis, please specify _____
- Adhesions, please specify _____
- Cysts, ovarian or other, please specify _____
- Other, please specify _____

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

- Chronic urethritis (pain with urination)
- Detrusor spasm/instability (urgency, incontinence)
- Interstitial or recurrent cystitis (bladder infection, burning, pain)
- Frequency of micturition (frequent urination)
- Incontinence (stress, urgency, overflow) please specify _____
- Other, please specify _____

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

- Continuous or recurrent abdominal pain
- Abdominal distension and bloating
- Problems with stool frequency/form/passage
- Passage of mucus
- None of the above
- Other, please specify _____

25. Do you suffer from any skin conditions or allergies?

- No
- Yes
If yes please specify: _____

26. Do you suffer from any muscle/joint/bone pain conditions? eg. fibromyalgia, arthritis, Sjogren's Syndrome etc.

No

Yes

If yes please specify: _____

27. Do you suffer from any of the following conditions?

Anxiety, including fears and phobias, please specify _____

Depression

Insomnia

Headache/migraine

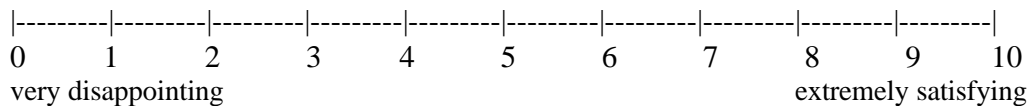
Other emotional/mental conditions, please specify _____

Sexual Health History

28. What was your age when you first became aware of pleasure from sexual self-stimulation? eg. touching, masturbating etc. _____

29. What was your age at the time of first sexual intercourse? _____

30. How satisfying was the experience to you?



31. Have you experienced any unwanted sexual activity or traumas as a child?

no

yes, please specify (optional) _____

32. Have you been involved in unwanted sexual activity as an adult?

No

Yes, please specify (optional) _____

33. Have you ever experienced conflict between your sexual desires and:

your parents attitudes _____

your friends attitudes _____

your partner's attitudes _____

your religious beliefs _____

none of the above _____

34. How many sexual partners have you had to date (include all sexual partners from single sexual encounters to those from longer term relationships)?

- _____ number of partners
- no sexual partners

35. How frequently do you and your partner have sexual intercourse?

- _____/ per day
- _____/ per week
- _____/ per month
- not at all
- other, please specify _____

36. How frequently would you like to have sexual intercourse?

- _____/ per day
- _____/ per week
- _____/ per month
- Not at all
- Other, please specify _____

37. For how long do you and your partner usually engage in sexual foreplay (touching, kissing, petting etc.)

- _____ minutes
- Not at all

38. How long does sexual intercourse usually last, from the time of penetration until male reaches orgasm? _____minutes, or orgasm not possible
female reaches orgasm? _____minutes, or orgasm not possible

39. Who usually initiates sexual activity?

- The female always
- The female most times
- Male and female equally as often
- The male most times
- The male always

40. Who would you like to have initiate sexual activity?

- The female always
- The female most times
- Male and female equally as often
- The male most times
- The male always

41. When your partner makes sexual advances, how do you usually respond?

- usually accept with pleasure
 - accept reluctantly
 - often refuse
 - usually refuse
42. When you have sex with your partner do you feel sexually aroused, feeling excited and aware of pleasurable physiological changes?
- nearly always, over 90% of the time
 - usually, about 75% of the time
 - sometimes, about 50% of the time
 - seldom, about 25% of the time
 - never
43. When you have sex with your partner, do you have negative emotional reactions, such as fear, disgust, shame or guilt?
- never
 - rarely, less than 10% of the time
 - seldom, less than 25% of the time
 - sometimes, 50% of the time
 - usually, 75% of the time
 - nearly always, over 90% of the time
44. Is the vagina ever so “dry” or “tight” that intercourse cannot occur?
- never
 - rarely, less than 10% of the time
 - seldom, less than 25% of the time
 - sometimes, 50% of the time
 - usually, 75% of the time
 - nearly always, over 90% of the time
45. If you try, is it possible for you to reach orgasm (sensation of climax) through sexual intercourse?
- nearly always, over 90% of the time
 - usually, about 75% of the time
 - sometimes, about 50% of the time
 - seldom, about 25% of the time
 - never
 - have never tried.
46. If you try, is it possible for you to reach orgasm (sensation of climax) through

having your genitals caressed by your partner?

- nearly always, over 90% of the time
- usually, about 75% of the time
- sometimes, about 50% of the time
- seldom, about 25% of the time
- never
- have never tried.

47. If you try, is it possible for you to reach orgasm (sensation of climax) through masturbating?

- nearly always, over 90% of the time
- usually, about 75% of the time
- sometimes, about 50% of the time
- seldom, about 25% of the time
- never
- have never tried.

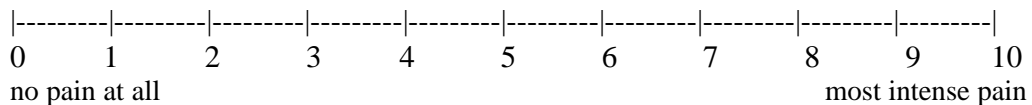
48. Do you ever experience pain/discomfort during or just after orgasm?

- No
- Yes

If yes, what is the location of the pain?

- Clitoris
- Opening of vagina
- Deeper in vagina
- Other, please specify _____

How would you rate the pain associated with orgasm?



49. Have you ever been diagnosed with a sexually transmitted disease?

- No
- Yes

If yes please specify

- Chlamydia
- Herpes
- Pelvic inflammatory disease
- Other, please specify _____

History of Vulval Pain or Discomfort

50. Do you feel pain in your genitals during sexual intercourse?

- never
- rarely, less than 10% of the time
- seldom, less than 25% of the time
- sometimes, 50% of the time
- usually, 75% of the time
- nearly always, over 90% of the time

51. Select the words that most accurately describe the nature of the problem

- rawness
- burning
- vulvar itching
- anal itching
- other, please describe _____

52. Is the severity of your condition

- stable
- getting worse
- improving
- other _____

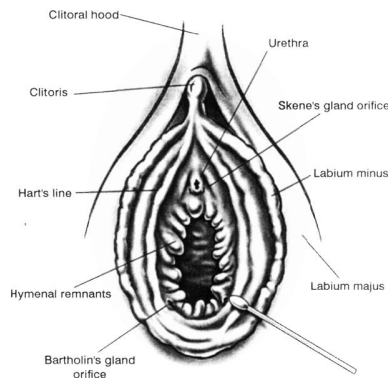
53. Since your pain problem began, which of the following treatments have you had?

- Medications, eg. pharmaceutical _____
- Surgery, types _____
- Physiotherapy _____
- Chiropractic/Osteopathic manipulation
- Nerve block, what type? _____
- TENS Unit
- Biofeedback/Relaxation training
- Counselling/Psychotherapy
- None of the above
- Other, describe _____

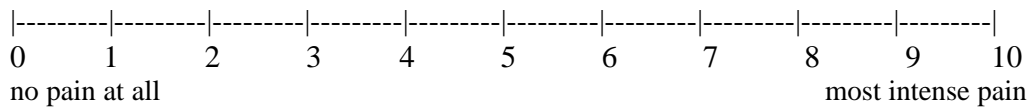
54. Do you ever have pain/discomfort in any of the following urogenital areas?

- Clitoris
- Labia (vaginal lips, outer genitals)
- Perineum (area of skin between vaginal opening and rectum)
- Urethra
- Rectum
- Other, please specify _____

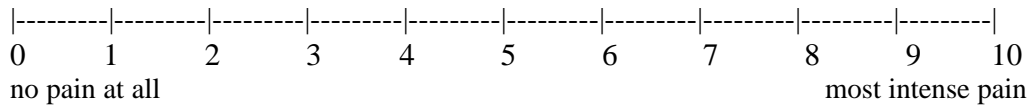
55. Please fill in the vulvar diagram, shading the areas affected by pain and discomfort



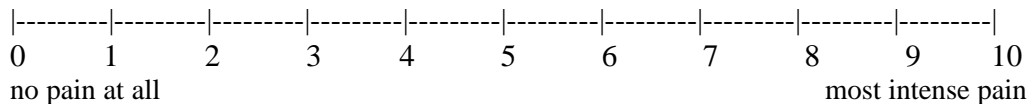
56. How would you rate the pain?



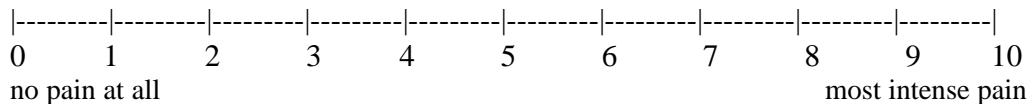
57. How would you rate the intensity of discomfort/pain at first penetration?



58. How would you rate the intensity of discomfort/pain during thrusting?



59. How would you rate the intensity of discomfort/pain post intercourse?

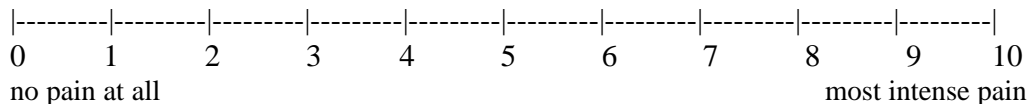


If you experience pain/discomfort after sexual intercourse is finished:

How long after sexual intercourse does it start? _____

How long does the pain/discomfort last? _____

60. What is the most severe that the intercourse pain has been?



61. Approximately how long ago did the pain begin? _____

62. Which of the following best describes the location of your pain during intercourse?

- Closer to the opening of the vagina
- Deeper in the vagina
- Both close to the opening of the vagina and deep in the vagina
- Other, rectum, stomach, etc, please specify _____

63. Are there any times when you are unable to insert the penis?

- No
- Yes

If yes, is this because of:

- Your pain
- Lack of lubrication
- Vaginal opening being too tense/muscle spasm
- Other, please specify _____

64. Have you noticed any changes in your sexual desire since the vulval pain/discomfort began?

- No
- Yes

If yes, has it

- Increased
- Decreased

65. Did it result in changes in frequency of sexual intercourse?

- Increased
Current frequency_____/ week. Previous frequency_____/ week.
- Decreased
Current frequency_____/ week. Previous frequency_____/ week.

66. Have you noticed any changes in your partner's sexual desire or sexual function?

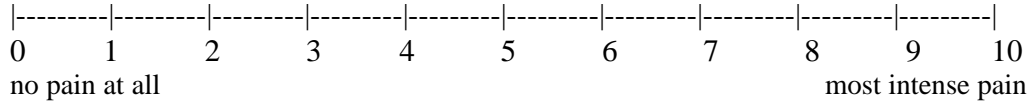
- No
- Yes, please specify _____

67. Do you still find sex enjoyable?

- No
- Yes

- Sometimes
68. Is the pain more intense with different intercourse positions?
- No
 Yes
 If yes, which of the position(s) is most uncomfortable/painful?
 Male on top
 Female on top
 Rear entry
 Other, please specify _____
69. Have you experienced the vulval pain/discomfort described above while:
- Exercising
 Bike riding
 Running/fast walking
 Sitting
 Passing urine
 None of the above
 Other, please describe _____
70. Does the level of pain increase with:
- Stress, anxiety and worry _____
 Tiredness _____
 The type of clothing you wear _____
 The food you eat _____
 None of the above
 Other, please specify _____
71. If you are in a relationship, how has your partner responded/reacted to your pain?
- Supportive
 Does not care
 Frustrated
 Angry
 Other, please specify _____
72. Have you noticed any changes in vulval pain with progression of your menstrual cycle? Does the pain increase?
- At ovulation
 Just prior to period
 Just after the period
 Other, _____
73. Does your pain level vary with the time of day?
- If yes, please specify
 Morning
 Afternoon
 Evening
 Night

74. If it is not possible to completely relieve your pain, what level of pain, could you live with?



75. If you obtain pain relief, which activities would you like to increase?

- Physical exercise/recreational activity
- Sexual activity
- Social activity
- Work activity
- Other, please specify _____

76. What is the total number of medical consultations you have sought in relation to vulval/pelvic/genital pain problems?

- 0
- 1 to 3
- 3 to 6
- 7 to 12
- 12 to 24
- more than 24

77. How many times in the past year have you sought medical consults because of vulval/pelvic/genital pain problem?

- 0
- 1 to 3
- 4-6
- 7 or more

78. How many times have you been admitted to a hospital in the past year for problems associated with vulval/pelvic/genital pain?

- 0
- 1-2
- 3 to 5
- more than 5

79. Do you think that your pain problem is due to something more serious than, or different from, what the doctors have told you?

- No
 - Yes
- If yes, what do you think is the possible cause of pain?
- _____

79. List below the family members who suffer from chronic vulval/pelvic/genital pain problems or related chronic illness.

Family Member(s)	Type of Illness	Approximate Dates

80. List any other medical problems you have other than the vulval pain/discomfort?

81. Would you like to participate in a support group consisting of vulval pain patients?

No

Yes

82. Do you consent to this information being used for research data collection purposes? The Information used will not identify you as a patient.

No

Yes

Signature _____ Date _____

Thank you for your cooperation.