

Vulvovaginal Services

Welcome to our practice! We look forward to meeting you!

Your appointment is scheduled on Date/Time: _____

Your appointment is at the following location:

	Burlington Women's Health, 20 Wall St., Burlington, MA 01803 Ph: 781-221-2940 Fax: 781-221-2854
	Somerville Ob/Gyn, 40 Holland St., Somerville, MA 02144 Ph: 617-629-6330 Fax: 617-629-6128

Important information before your visit:

- Enclosed you will find a patient information packet and new patient questionnaire. Please return your COMPLETED questionnaire, any outside records (only for the issue you are being seen for) and a signed No Show policy. Our Fax # and address are listed above. If you are mailing the questionnaire, please allow at least 7 business days for the paperwork to reach our office. Once your paperwork is received, we will call you to arrange an appointment with one of our providers.
- At your request, we can send a copy of your visit notes to your referring provider to include them in your care.
- Please review the "Medication Management" information below at least two weeks before your appointment to prepare for your visit.
- We understand that symptoms can come and go. If you are not having symptoms on the day of your scheduled visit, please keep the appointment so we can obtain a baseline evaluation. We can see you again when your symptoms return.

The Day of Your Visit:

- Since traffic can be heavy near our office, allow ***extra time*** for travel, especially if you have not been to our office before.
- Please arrive at least 15 minutes before your scheduled appointment time.
- When you arrive:
 - Please check in at the Main Desk
 - Check in a second time with the secretaries in our department so we know you are here!
- Appointments can be lengthy. Please allow ample time in your schedule.

PLEASE SEE REVERSE SIDE FOR MORE INFORMATION

If Your Plans Change:

- If you need to cancel your appointment, please notify us at least 2 business days in advance so that someone else may be scheduled.

Sending Medical Records (Non-Atrius Patients Only):

- Please have your records forwarded to us ***before*** your appointment if you ***do not*** receive your care from an Atrius Health provider.
- We will need records from any other provider who has treated this condition for you, including the results of any cultures or biopsies.
- Enclosed please find an “Authorization to Obtain Medical Records” which you can fill out and send to your referring provider in order to release your records to us.
- Records can be faxed to us (up to 15 pages) or mailed.

Managing Medications Before Your Visit

Some medications and treatments which you are currently using can make it more difficult for us to determine what is causing your symptoms.

- TWO WEEKS prior, please do not apply any external:
 - Topical creams, ointments, over-the-counter remedies
 - Prescribed topical medications (like topical steroids) on the skin surrounding the vaginal opening).
- ONE WEEK prior, please avoid using the following internal vaginal medications:
 - Antibiotic creams, anti-yeast medications, vaginal creams or suppositories
- 48 HOURS prior please avoid:
 - Intercourse, Estradiol, Estrace or Premarin cream, inserting Vagifem vaginal tablets
 - Estring may stay in place for your appointment
- Please ***DO NOT*** wear a tampon to your visit.
- Refer to the “Rescue Tips for Vulvar Skin Care” in your packet to provide some comfort measures to try before your visit.

Vulvovaginal Service Questionnaire

Date _____ **Name** _____ **Nickname** _____ **Date of Birth** _____

Who referred you to us? (please include address) _____

Your occupation _____

Are you in a relationship? (please circle) Married, single, single and in a relationship, living with partner, separated, divorced, widowed, dating, not in a relationship

How long have you been in your current relationship? _____

Is your partner (please circle): **Male Female Both**

How many pregnancies have you had? ____ **How many children do you have?** _____

How many vaginal deliveries? _____ **C-Sections?** _____

In a few words, please tell us your primary problem: _____

History: _____

Please tell us about your symptoms. For example, when did symptoms first occur? Do you know what caused them? Do you have itching, burning, irritation, etc...? Are symptoms present all the time, some of the time? How severe are your symptoms? Do you have pain with sexual activity? Do you have concerns about sexual functioning? What else?

What makes your symptoms worse?

What makes your symptoms better?

What have you tried to improve your symptoms? (please include medications prescribed as well as lifestyle changes, such as “wearing no underwear” etc...)

Current Medications and dosages:

Medication Allergies: (please list drug and reaction)

Please check the products you use and write in the brand names:

Bath Soap/Bubble bath: _____ Detergent: _____

Fabric Softener/ Dryer sheets: _____ Bleach: _____

Sanitary Pads: _____ Tampons: _____

Panty liner: _____ Douche: _____

Wipes: _____ Adult diapers: _____

Thong underwear: _____ Other: _____

Do you use **daily** panty liners or other protection in your underwear? _____

Your gynecologic history and/or problems:

Do you have **regular periods**? _____ If not, why? _____

Are you **menopausal**? _____ If yes, at what age? _____

Have you ever used **hormone replacement** (oral pills, patch or topical creams/gels) Yes / No / Currently taking

Are you sexually active? ____ If no, have you ever been sexually active? ____ N/A

If any, what type of **birth control** do you use? _____

Have you had any of the following (please circle): ovarian cyst, PCOS, fibroids, endometriosis, pelvic surgery, DES exposure (born before 1974) perimenopause, menopause, other:

Have you had an abnormal pap? _____ When? _____ What treatments have you had for abnormal pap? (colposcopy, LEEP, surgery etc.) _____

Vulvovaginal disorders (please circle): yeast, bacterial vaginosis, herpes, chlamydia, gonorrhea, syphilis, genital warts, molluscum, lichen planus, lichen sclerosus, trichomonas, Bartholin’s cyst, other:

Have you ever had a vulvar biopsy? No Yes

Do you have any history of genital injury or trauma? No Yes

Do you have a history of sexual abuse/assault? No Yes

Do you have problems in any of the following of the following areas?

Urinary: (please circle) pain with urination, frequent urination, need to go urgently, up at night to urinate more than once, bladder pain, interstitial cystitis, urinary leakage, frequent bladder or kidney infections, other: _____

Gastrointestinal: (please circle) diabetes, constipation, diarrhea, GERD/reflux, irritable bowel syndrome, abdominal pain, rectal fissures, hemorrhoids, rectal bleeding, stomach ulcers, Other: _____

Musculoskeletal: (please circle) back injury, chronic back pain, herniated disc, sciatica, back surgery, coccyx injury, hip problems, scoliosis, one leg longer than the other , hips are uneven, hips or pelvis rotated, problems with posture or gait, other: _____

Participated in: (please circle) gymnastic, ballet, running, horseback riding, cheerleading, hockey, football, figure skating, boxing or kick boxing, martial arts, other: _____

Dermatologic: (please circle) problems in your mouth, itching of the skin, scaling, dermatitis, eczema, psoriasis, shingles, skin allergies, other: _____

Mental Health: (please circle) depression, anxiety, high stress, general poor health, lack of emotional support, dissatisfaction with life, difficult relationship, inadequate sleep, distress about vulvar condition, previous diagnosis of obsessive/compulsive disorder (OCD), bipolar, frequent severe headaches, other: _____

Have you had any surgeries? Please list them with dates.

1.

2.

3.

Medical History:

Condition	Have currently	Had in past	If have or had, explain:
Cancer			
Autoimmune condition			
Vitamin D Deficiency			
Problems with your eyes, ears, nose, throat, mouth			
Heart Disease			
High Cholesterol			
Hypertension			
Breast Disease			
Asthma or lung problems			
Ulcerative Colitis or Crohn Disease			
Liver Disease			
Kidney Disease			
Thyroid Disease			
Diabetes			
Fibromyalgia			
Headaches			
Depression, Anxiety			
Other			

Family History:

Do any family members have the following conditions? (please indicate which family member):

Lichen sclerosus: _____ Lichen planus: _____

Hidradenitis Suppurativa: _____ Psoriasis: _____

Thyroid disease: _____ Crohn's Disease _____

Vulvovaginal disorders: _____ Autoimmune diseases: _____

Irritable bowel syndrome: _____ Rheumatoid arthritis: _____

Diabetes: _____

Social History:

Have you ever smoked? ____ If yes, how many cigarettes do you smoke in a day? ____

Do you use an E Cigarette? _____

Do you consume alcohol? ____ If yes, how many alcoholic beverages per week? ____

Do you use recreational drugs? _____ If yes, what recreational drugs do you use? _____

Do you exercise regularly? _____ If yes, what regular exercise do you do? _____

Patient Notification of Vulvar Specialty Late Arrival, Cancellation and No Show Policy

The appointment late arrival and cancellation policy for Atrius Health's Vulvovaginal Service is as follows:

1. We ask all patients who are scheduled for an appointment in the Vulvovaginal Service to give at least 2 business days' notice (48 hours) when cancelling an appointment.
2. Each patient is responsible for knowing:
 - Whether or not a referral is required by insurance prior to being seen
 - If the referral is required from your Primary Care Physician and how many visits have been requested
 - What your co-payments or deductibles are for your insurance carrier
4. Patients are responsible for communicating any changes in insurance coverage to the Main Reception Desk at the location they are receiving treatment prior to visit. The patient is responsible for any charges not covered by their insurance.
5. If you are going to be late for your appointment, please call the office ahead of time to inform reception of predicted arrival time. If you are unable to be here at your scheduled time, your appointment may be delayed or rescheduled to a different date.
6. Patients may be asked to seek care from a Vulvovaginal Specialist provider outside of the Atrius Health network if appointments are continuously missed or cancelled.

Rescue Tips for Vulvar Skin Care

While you are awaiting treatment from us for your problem, here are some comfort measures that might relieve symptoms and prevent further irritation. These irritants may not be the cause of your symptoms, but they could be making them worse.

As a woman with a history of vulvar skin problems, you should try these guidelines to prevent flares, even when you are feeling well. After your symptoms are under control, you can restart any routines that are important to you.

- Wash the vulva no more often than once per day, using water only. Do not use a wash cloth or scrubber, but only soft finger tips.
- Avoid: soap, douches, powders, or over-the-counter medications (especially “Vagisil” or anything containing benzocaine)
- If any prescribed topical medications produce burning, stop using them and call your provider.
- If you have sensitive skin, you might try applying a new medication on a ‘test patch’ on your inner thigh before applying it to your vulvar skin. This is to make sure your skin will tolerate it.
- Do not use daily panty liners (especially the brand “Always”). If you feel that you must use panty liners, use ones which are 100% cotton, such as “Natracare” brand, which may be found at Whole Foods or on the Web at www.natracare.com.
- “Glad Rags” are reusable cloth inserts which snap around the crotch of your panties to collect vaginal secretions and menstrual blood, and may be less irritating than pads. You can find them at www.gladrags.com.
- Consider Period Panties, which combine an absorbent and leak-proof crotch into several styles of attractive underwear. “Thinx” is one of several brands, and can be found at www.shethinx.com.
- With periods, use tampons rather than pads if this is comfortable for you.
- Prevent constipation by adding fiber to your diet. An easy solution is one or two large helpings of a very high fiber cereal such as “All Bran” or “All Bran Extra”, with large amounts of fluid. Docusate 100 mg over-the-counter gel caps can be useful if used regularly, starting at one capsule once or twice per day and increasing if needed. Miralax is also safe and often effective.
- Apply ice, a bag of frozen peas or corn or a frozen blue gel pack (lunch box size) wrapped in a hand towel to relieve burning. Make sure to have a layer of cloth between the cold source and your skin, and do not overdo it, since it is possible to give yourself frostbite.
- Use a lubricant with sexual activity. Women with vaginal symptoms tend to struggle with vaginal dryness. Good choices are: Astroglide, Slippery Stuff, Wet Platinum, Uberlube, and cold pressed extra virgin coconut oil.
- Apply a generous amount of topical anesthetic: lidocaine, prilocaine or xylocaine (NOT benzocaine or Vagisil) to your vaginal entrance 15-30 minutes before sexual activity if sex is painful for you. Then wipe it off just before having sex so your partner does not get numb. These preparations may sting momentarily when first applied, but this should resolve promptly.
 - Try not to get the anesthetic on your clitoris, since this can diminish your own enjoyment.
 - Topical anesthetics can also help reduce discomfort from gynecologic exams and pelvic floor physical therapy.
- Contraceptive creams or films, spermicides, and latex condoms can all be irritating. Try non-latex or polyurethane condoms, and avoid condoms which contain spermicides.

Please let us know of any tips you have learned so we can share them with our other patients!

Patient Instructions and Information:

- Please complete this form and mail to former healthcare provider to request a copy of your medical record. *Please be aware that medical record copy fees may apply and contacting your former healthcare provider for specific medical*

Authorization to Obtain Medical Records

Patient's Name: _____ Date of Birth: _____
(Please Print)

Address: _____
Street City State Zip Telephone No.

I do hereby, authorize _____
Name of Physician, Facility or Person

Located at _____
Street City State Zip

To release protected health information, contained in the medical record of the above-named patient to the following Atrius Health clinician:

Dr.

Atrius Health

Street

City State Zip

Special Authorization for Release of Statutorily Protected Information from the Medical Record

I understand the following categories of information may be in the medical record and ***SHOULD NOT*** be released unless specifically authorized as indicated by my checking and initialing each appropriate category.

- | | | |
|--|---|--|
| <input type="checkbox"/> ___ Abortion | <input type="checkbox"/> ___ Behavioral/Mental Health | <input type="checkbox"/> ___ HIV/AIDS Results/Treatment |
| <input type="checkbox"/> ___ Alcohol/Drug Abuse | <input type="checkbox"/> ___ Domestic Violence | <input type="checkbox"/> ___ Child/Elder/Disabled Abuse |
| <input type="checkbox"/> ___ Rape/Sexual Assault | <input type="checkbox"/> ___ Genetic Testing | <input type="checkbox"/> ___ Sexually Transmitted Diseases |

Information to be released:

- Dates of Treatment to be Released: _____ to _____ LI Laboratory Result LI X-ray (Reports Only)
- Office Notes: _____ LI Immunization Record LI Complete Record
Specify Clinician(s)
- Other:

Purpose of Release: LI Medical Care LI Other:

I understand that once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not redisclose my health information to a third party. Such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke this Authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment. I understand that this authorization will expire 90 days from the date of said authorization unless I provide a written notice of revocation to the releasing facility noted above.

Signature of Patient or Authorized Representative

Date

Printed Name of Patient or Authorized Representative

Relationship to Patient