

# VULVOVAGINAL PAIN LOG

NAME

DATE

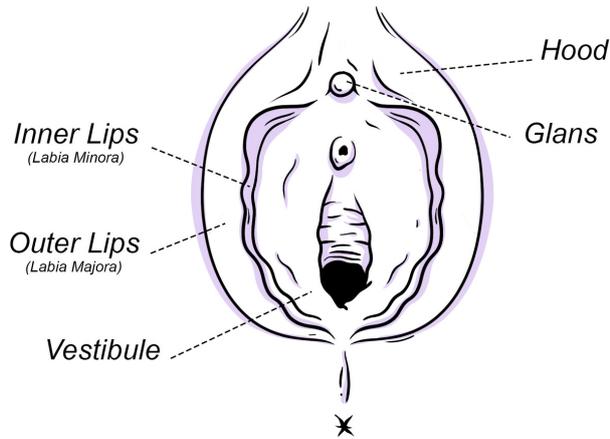
**Where Do You Feel Pain?**

Internal

External

Both

**Be Specific (Circle/Mark Pain Area)**



**Internal Pain? Describe Where:**

**Pain Sensation (circle all that apply)**

- |         |           |                   |
|---------|-----------|-------------------|
| Burning | Dull      | Pins and Needles  |
| Gnawing | Stabbing  | Itchiness         |
| Sharp   | Swelling  | Other (Describe): |
| Crampy  | Radiating |                   |

**What Brings Relief? (circle all that apply)**

- Heat      Rest      Standing      OTC Vaginal Lubricant (Specify):
- OTC Medications (Specify):      Other (Specify):

**Triggers**

- |             |               |                |               |
|-------------|---------------|----------------|---------------|
| Touch       | <b>Y or N</b> | Food           | <b>Y or N</b> |
| Sitting     | <b>Y or N</b> | Bowel Movement | <b>Y or N</b> |
| Walking     | <b>Y or N</b> | Urination      | <b>Y or N</b> |
| Intercourse | <b>Y or N</b> | Other:         |               |

**Do You Have?**

- |                   |               |
|-------------------|---------------|
| Vaginal Discharge | <b>Y or N</b> |
| Vaginal Dryness   | <b>Y or N</b> |
| Painful Urination | <b>Y or N</b> |
| Genital Sores     | <b>Y or N</b> |

- Pain During Sex?      **Y or N**
- Do you use lubricant?      **Y or N**
- If yes, what type:
- Do you have a history of sexual abuse, assault, or rape?      **Y or N**



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## Monthly Review

To Use:

Mark the dates of the month in the top left corner of each box.

Place a "P" on each day you experience pain, and rate with a number from 1-10 (i.e. P-3)

Be sure to indicate your period with an "M" (Menses).

Keep track of any notes that you want to share with your Health Care Provider.


**Notes:**