

**9. Have you experienced any of the following vaginal symptoms recently?**

Please check all that apply:

<u>Today</u>	<u>Past 2 Months</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Itching or burning
<input type="checkbox"/>	<input type="checkbox"/>	Unpleasant vaginal odor (may be stronger after sex)
<input type="checkbox"/>	<input type="checkbox"/>	Increased discharge
<input type="checkbox"/>	<input type="checkbox"/>	Discharge that is thick, white, and cottage cheese-like
<input type="checkbox"/>	<input type="checkbox"/>	Discharge that is thin, milky-white, or gray
<input type="checkbox"/>	<input type="checkbox"/>	Discharge that is yellow-green and frothy
<input type="checkbox"/>	<input type="checkbox"/>	Other symptoms (please describe) _____

**10. Have you ever used an over-the-counter yeast medication?**

(For example Monistat, Mycelex, Gyne-Lotrimin)  Yes  No

**11. Do you ever douche?**

If yes, how often? \_\_\_\_\_  Yes  No  
When did you last douche? \_\_\_\_\_

**12. What method of birth control do you currently use?** \_\_\_\_\_

**13. Have you ever had vaginal intercourse (sex)?**

Are you sexually active now?  Yes  No  
Have you recently had sex with a new partner?  Yes  No  
If yes, was your last partner male or female?  Male  Female

**14. Life Style:**

Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_  
Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_  
Do you use street drugs?  Yes  No If yes, what type/how much? \_\_\_\_\_

**15. Have you experienced emotional change recently?**  Yes  No

If yes, please explain \_\_\_\_\_

**16. Do you do monthly self-breast exams?**

Yes  No  
If no, why? \_\_\_\_\_

**17. Is there anything else you would like to discuss with your physician?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

<b>For Office Use Only</b>
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