



Student Health Centers

Women's Health Department Initial History

Name: _____ SS#: _____ Date of Birth: _____ Age: _____

A. HEALTH HISTORY

Have you or your immediate family (blood relatives - parents, grandparents, sisters, brothers) had any of these problems?

	SELF		FAMILY		
	YES (Please clarify)	NO	YES (Please clarify)	NO	
Are you adopted?					Please list any allergy to metals, latex, food or medications: _____
Migraine headaches (Aura?)					
Heart Attack (before 50)?					Please list any medications you are taking (including birth control pills): _____
Heart valve defect?					
Stroke?					_____
Epilepsy/seizures?					
Suicide attempts?					Have you used street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma?					
Thyroid problems?					How taken into the body? _____
TB/positive TB skin test?					
High blood pressure?					Date last used: _____
High cholesterol/fat?					How many alcoholic drinks do you consume?
Anemia? (Including sickle cell)					#per day _____
Depression/anxiety?					#of days per week _____
Sleep disturbance/other psychiatric problems?					Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism/drug abuse?					# a day _____
Hepatitis/liver disease?					# of years _____
Gall bladder disease?					List any hospitalizations: <input type="checkbox"/> Yes <input type="checkbox"/> No
Eating Disorder?					Date(s) _____
Cancer: <input type="checkbox"/> Colon <input type="checkbox"/> Breast <input type="checkbox"/> Ovarian					Kind _____
<input type="checkbox"/> Gained 15lbs <input type="checkbox"/> Lost 15 lbs in past 6 mos.					Reason: _____
Genetic disorders? Other/chronic disease?					_____
Diabetes?					List any surgeries you've had:
Overweight?					Date: _____
Kidney problems?					Kind: _____
Bladder problems?					_____
Bleeding disorder? Thalasimia,					Reason: _____
Blood clot/Phlebitis/DVT?					_____

Comments: _____

Name: _____ SS#: _____

B. GYNECOLOGICAL HISTORY (Important - Fill out)

1. Age when you started your period _____ How many days to you normally bleed? _____
2. Unusual or missed period? Yes No
3. How many pads or tampons do you use during your heaviest days of flow? _____
4. How many days do you have from the **start** of one period to the **start** of the next? _____
5. Menstrual cramping/pain with period? Yes No
6. Are you able to relieve this pain? Yes No
7. Do you miss activities because of this pain? Yes No
8. Month/Year of Last PAP Smear: _____/_____
9. Have you ever had an abnormal PAP? Yes No If yes, when and what were the results?

10. What types of treatment (if any)? Did you have a colposcopic procedure, LEEP, CRYO, LASER CONE, Biopsy?

11. Have you ever been told you have a problem with your uterus, cervix, ovaries, vagina, and/or breast?
 Yes No
12. Any reproductive abnormalities? Yes No

C. SOCIAL HISTORY:

Have you been affected by any of the following:

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you feel you have a good social support network? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you satisfied with your body image, body weight, and/or eating patterns? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you aware we have a nutritionist available for consultation? |
| <input type="checkbox"/> | <input type="checkbox"/> | Major physical illness. Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your partner (husband, boyfriend, girlfriend) ever made you have sex against your will? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you afraid of your partner? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you, or have you ever been a victim of family/domestic violence? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been a victim of a violent crime, or a sexual assault? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever seen a mental health professional? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there anything going on in your life currently that may be helped by a mental health professional?
_____ |

D. SEXUAL AND CONTRACEPTIVE HISTORY (If you have never been sexually active, you may skip to Section E.)

1. Have you ever had a sexual experience? Yes No
 - a. male partner female partner
 - b. vaginal sex oral sex anal sex
2. Current sexual orientation? _____
3. How long have you been sexual with your present partner(s)? _____
4. Last time you had sex? _____
5. How old were you when you first had sex? _____
6. How many sex partners have you had in your life? _____
7. What do you use to protect yourself from sexually transmitted disease (STD)? _____
8. Do you know that you can get Chlamydia, gonorrhea, herpes, as well as other sexually transmitted diseases from oral sex? Yes No
9. Is there any other information about yourself you think we should discuss? _____
10. Since your last period, have you had sex without using a birth control method? Yes No
11. # of pregnancies _____ # of live births _____ # of miscarriages _____ # of elective terminations

<p>Please (check) all contraceptive methods currently used, or used in the past:</p> <table border="0"> <tr> <td><input type="checkbox"/> Abstain (no sex)</td> <td><input type="checkbox"/> Implanon</td> </tr> <tr> <td><input type="checkbox"/> Birth Control Pills</td> <td><input type="checkbox"/> Rhythm/Counting Days</td> </tr> <tr> <td><input type="checkbox"/> Condoms</td> <td><input type="checkbox"/> Sponge</td> </tr> <tr> <td><input type="checkbox"/> Depo</td> <td><input type="checkbox"/> Sterilization</td> </tr> <tr> <td><input type="checkbox"/> Foam/Cream/Suppository</td> <td><input type="checkbox"/> Withdrawal</td> </tr> <tr> <td><input type="checkbox"/> I.U.D.</td> <td></td> </tr> </table>	<input type="checkbox"/> Abstain (no sex)	<input type="checkbox"/> Implanon	<input type="checkbox"/> Birth Control Pills	<input type="checkbox"/> Rhythm/Counting Days	<input type="checkbox"/> Condoms	<input type="checkbox"/> Sponge	<input type="checkbox"/> Depo	<input type="checkbox"/> Sterilization	<input type="checkbox"/> Foam/Cream/Suppository	<input type="checkbox"/> Withdrawal	<input type="checkbox"/> I.U.D.		COMMENTS
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<p>Have you ever had (please check):</p> <table border="0"> <tr> <td><input type="checkbox"/> Chlamydia</td> <td><input type="checkbox"/> PID/pelvic inflammation disease</td> </tr> <tr> <td><input type="checkbox"/> Gonorrhea</td> <td><input type="checkbox"/> Syphilis</td> </tr> <tr> <td><input type="checkbox"/> Herpes</td> <td><input type="checkbox"/> Trichomonas</td> </tr> <tr> <td><input type="checkbox"/> HIV</td> <td><input type="checkbox"/> Warts</td> </tr> <tr> <td><input type="checkbox"/> HPV</td> <td></td> </tr> </table>	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> PID/pelvic inflammation disease	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Herpes	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> HIV	<input type="checkbox"/> Warts	<input type="checkbox"/> HPV		COMMENTS
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<p>Has a partner (to your knowledge) ever had any of the above? Please list:</p> <p>_____</p> <p>_____</p> <p>_____</p>	COMMENTS
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E. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT AND COMPLETE.

I understand I will be charged a fee for all lab work (i.e., pap smear, Chlamydia, etc.)

Patient's signature: _____ SS# _____ DATE _____

INITIALS/CLINICIAN REVIEWING HISTORY _____ DATE _____