

WOMEN'S HEALTH HISTORY FORM

Name: _____
 Date of Birth: ____/____/____ Age: _____
 Student ID#: _____
 Cell Phone Number: _____
 Marital Status: Single Married Divorced

REASON FOR VISIT

- Annual Exam Pregnancy Test Plan B
 Problem Exam Pap Only STD Testing
 Birth Control (BC) Start BC Renew BC Problem

ALLERGIES

- None Known Latex
 Drugs _____

YOUR MEDICAL HISTORY —Check any for which you have been diagnosed or treated.

- Abnormal Vaginal Bleeding Hepatitis/ Liver problems
 Blood Clots High Blood Pressure
 Breast Problems Menstrual Cramps, severe
 Chlamydia Migraine Headaches
 Depression Ovarian Cysts
 Diabetes Pain or Bleeding w/ intercourse
 Eating Disorder Pelvic Inflammatory Disease (PID)
 Endometriosis Polycystic Ovarian Syndrome (PCOS)
 Genital Herpes Thyroid Disease
 Genital Warts **Other:**
 Gonorrhea **NONE**

FAMILY HISTORY — Check any that apply to family member(s).

- Adopted Heart Disease or Heart Attack
 Breast Cancer High Cholesterol
 Blood Clots Ovarian Cancer
 Cervical Cancer Polycystic Ovarian Syndrome
 Diabetes Stroke
 High Blood Pressure Thyroid Disease
 Other: **NONE KNOWN**

Have you had the HPV Vaccine (Gardasil or Cervarix)?

- No Yes, all three Two of Three One only

Has there been *past or current* domestic violence or sexual abuse?

- No Yes

YOUR MENSTRUAL HISTORY

First Day of Your Last Period (mm-dd-yyyy) ____-____-____
 Age of Onset of Period _____ Years Old
 Are your periods regular (21-38 days apart) or irregular?
 How long does your period last? _____ days

What **medications** (birth control, vitamins, supplements, etc.) do you take?

- None Names of medications _____

YOUR PAP HISTORY

Have you ever had a pap test before? Yes No
 Had an abnormal pap? Yes No
 Date of **abnormal** pap if you've had one: _____
 Date of last Pap smear _____

YOUR SEXUAL HISTORY

- I have **not** had intercourse, (vaginal, oral) or skin to skin contact
 I have had intercourse: oral, vaginal, anal (Circle what applies)
 Gender of Partner(s) Male Female
 Total number of partners in your lifetime _____
 Length of current sexual relationship _____
 Age at first intercourse _____

YOUR PREGNANCY/ CONTRACEPTION HISTORY

Have you ever been pregnant? Yes No
 Number of pregnancies: ____ Number of live births: ____
 Condom use: Always__ Most of the time__ Sometimes__ None__
 Check the contraceptive method(s) you currently use:
 Abstinence Patch Implant IUD
 Pill Depo Pulling out/Withdrawal
 Ring Condoms Surgical **NONE**
 Are you happy with your present method? Yes No

HABITS

- Do you smoke? No Yes Amount _____
 Do you drink? No Yes Amount _____
 Do you exercise? No Yes Amount _____

Patient Signature _____

Today's Date: _____ **Reviewed:** _____ NP/MD

Updated: _____ **By:** _____