

**SCSU Health Service Woman's Health History**

**NAME (please print)** \_\_\_\_\_ **DOB** \_\_\_\_\_

**PHONE** \_\_\_\_\_ **HOME ADDRESS** \_\_\_\_\_

**1. ALLERGIES:** No Known \_\_\_\_\_

Yes (list) \_\_\_\_\_

**2. MEDICATIONS:** \_\_\_\_\_

**MEDICAL/ GYN HISTORY:**

Adopted/ Family history unknown Yes \_\_\_\_\_

Check if you have had any of the below:

3. Diabetes: Yes \_\_\_\_\_ Family HX \_\_\_\_\_

4. Heart murmur Yes \_\_\_\_\_

5. High Blood Pressure Yes \_\_\_\_\_

6. Blood Clots Yes \_\_\_\_\_

7. Thyroid Disease Yes \_\_\_\_\_

8. Anemia Yes \_\_\_\_\_

9. Asthma Yes \_\_\_\_\_

10. Blood Transfusions Yes \_\_\_\_\_

11. HIV or AIDS Yes \_\_\_\_\_

12. Breast Cancer Yes \_\_\_\_\_ Family HX \_\_\_\_\_

13. Migraine Headaches Yes \_\_\_\_\_

14. Depression Yes \_\_\_\_\_

15. Breast problems Yes \_\_\_\_\_

16. Eating disorder Yes \_\_\_\_\_

17. Chlamydia Yes \_\_\_\_\_

18. Gonorrhea Yes \_\_\_\_\_

19. Herpes Yes \_\_\_\_\_

20. Syphilis Yes \_\_\_\_\_

21. Genital wart virus Yes \_\_\_\_\_

22. Vaginal yeast infection Yes \_\_\_\_\_

23. Bacterial Vaginosis (BV) Yes \_\_\_\_\_

24. Trichomonas Yes \_\_\_\_\_

25. Pelvic Infections Yes \_\_\_\_\_

26. Sexual Abuse/Assault/Incest Yes \_\_\_\_\_

**27. HOSPITALIZATIONS/ SURGERIES** \_\_\_\_\_

\_\_\_\_\_

**28. PREGNANCY HISTORY:**

# of Pregnancies \_\_\_\_\_ # of Deliveries \_\_\_\_\_

# of Miscarriages \_\_\_\_\_ # of Abortions \_\_\_\_\_

# of living children \_\_\_\_\_

**LIFESTYLE (Check all that apply)**

29. Alcohol: No \_\_\_\_\_ Yes \_\_\_\_\_

Type & amount/week \_\_\_\_\_

30. Tobacco: No \_\_\_\_\_ Yes \_\_\_\_\_ Quit \_\_\_\_\_

31. Illicit drugs No \_\_\_\_\_ Yes \_\_\_\_\_

Type & amount/week \_\_\_\_\_

**PAP TEST HISTORY:**

32. Have you ever had a GYN exam? No \_\_\_\_\_ Yes \_\_\_\_\_

33. Have you ever had a PAP test? No \_\_\_\_\_

Yes \_\_\_\_\_ Date of Last PAP \_\_\_\_\_

34. Have you ever had an abnormal PAP? No \_\_\_\_\_ Yes \_\_\_\_\_

35. Have you ever been treated for an abnormal PAP No \_\_\_\_\_ Yes \_\_\_\_\_

**36. Contraception History:**

Not applicable \_\_\_\_\_ Abstinence \_\_\_\_\_ Condoms \_\_\_\_\_

Birth control pills \_\_\_\_\_ NuvaRing \_\_\_\_\_ Patch \_\_\_\_\_

IUD \_\_\_\_\_ Depo Provera \_\_\_\_\_ Implanon \_\_\_\_\_ Other \_\_\_\_\_

**SEXUAL HISTORY:**

37. Have you ever had any sexual activity? No \_\_\_\_\_ (skip to #45 Yes \_\_\_\_\_)

38. Do you have sex with: Men \_\_\_\_\_ Women \_\_\_\_\_ Both \_\_\_\_\_

39. How old were you when you first had any kind of sex? \_\_\_\_\_

40. About how many sexual partners have you had in your life? \_\_\_\_\_

41. Do you have: Oral sex \_\_\_\_\_ Anal sex \_\_\_\_\_ vaginal intercourse \_\_\_\_\_

42. Is sex painful for you? No \_\_\_\_\_ Yes \_\_\_\_\_

43. New sexual partner in the last 3 months? No \_\_\_\_\_ Yes \_\_\_\_\_

44. When was your last sexual intercourse? \_\_\_\_\_

**45. MENSTRUAL HISTORY:**

First day of last period \_\_\_\_/\_\_\_\_/\_\_\_\_

Problems: Heavy bleeding \_\_\_\_\_ Long periods \_\_\_\_\_

Irregular periods \_\_\_\_\_ Other \_\_\_\_\_

**46. PRESENT SYMPTOMS:**

Vaginal symptoms now? No \_\_\_\_\_ Yes \_\_\_\_\_

Unusual Discharge? No \_\_\_\_\_ Yes \_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_

47. Do you have anything further that you would like to discuss?

No \_\_\_\_\_ Yes \_\_\_\_\_

Your signature \_\_\_\_\_ Date \_\_\_\_\_