

University of Connecticut Student Health Services, Storrs, CT
Women's Clinic Health History

PATIENT NAME (PLEASE PRINT)				TODAY'S DATE AND APPT TIME	
SSN	DATE OF BIRTH	AGE	Semester Status	Cell Phone	
School Address				School Phone	
Home Address				Home Phone	
1. ALLERGIES (<i>Medications, foods, latex, etc</i>) <input type="checkbox"/> None <input type="checkbox"/> Yes (Please list)			PAP TEST HISTORY 40. Have you ever had a regular GYN exam? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of last exam _____ 41. Have you ever had a PAP test? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of last exam _____ 42. Have you ever been evaluated or treated for an abnormal PAP test? <input type="checkbox"/> No <input type="checkbox"/> Yes		
2. MEDICATIONS: (<i>Include birth control pills, herbal/vitamin/nutritional supplements</i>)			43. CONTRACEPTION HISTORY (<i>Check all that apply</i>) <input type="checkbox"/> Not Applicable <input type="checkbox"/> Birth control pills <input type="checkbox"/> Abstinence <input type="checkbox"/> Condoms <input type="checkbox"/> Spermicides <input type="checkbox"/> Diaphragm <input type="checkbox"/> Sponge Name of Pill(s) _____ <input type="checkbox"/> IUD Type & date inserted _____ Dates used Pill _____ <input type="checkbox"/> OrthoEvra _____ <input type="checkbox"/> Depo Provera _____ <input type="checkbox"/> Nuva Ring _____ Date started _____ <input type="checkbox"/> Plan B last used _____ Date Last Shot _____ <input type="checkbox"/> Sterilization		
MEDICAL/GYN HISTORY (CHECK APPROPRIATE BOX) (FAMILY MEANS Mother Father Sister Brother) <input type="checkbox"/> Adopted - family history not known Have you or family members had YOU FAMILY 3. High cholesterol..... <input type="checkbox"/> <input type="checkbox"/> 4. Heart disease <input type="checkbox"/> <input type="checkbox"/> 5. Rheumatic fever or heart murmur <input type="checkbox"/> <input type="checkbox"/> 6. High blood pressure <input type="checkbox"/> <input type="checkbox"/> 7. Blood clots <input type="checkbox"/> <input type="checkbox"/> 8. Asthma <input type="checkbox"/> <input type="checkbox"/> 9. Diabetes <input type="checkbox"/> <input type="checkbox"/> 10. Thyroid disease <input type="checkbox"/> <input type="checkbox"/> 11. Liver disease <input type="checkbox"/> <input type="checkbox"/> 12. Hepatitis <input type="checkbox"/> <input type="checkbox"/> 13. Anemia or blood diseases <input type="checkbox"/> <input type="checkbox"/> 14. Blood transfusion..... <input type="checkbox"/> <input type="checkbox"/> 15. Stomach/bowel/gallbladder disease. <input type="checkbox"/> <input type="checkbox"/> 16. Kidney or bladder problems/UTI..... <input type="checkbox"/> <input type="checkbox"/> 17. HIV or AIDS <input type="checkbox"/> <input type="checkbox"/> 18. Mononucleosis..... <input type="checkbox"/> <input type="checkbox"/> 19. Cancer <input type="checkbox"/> <input type="checkbox"/> 20. Birth defects or inherited disease <input type="checkbox"/> <input type="checkbox"/> 21. Epilepsy or convulsions <input type="checkbox"/> <input type="checkbox"/> 22. Migraines <input type="checkbox"/> <input type="checkbox"/> 23. Depression <input type="checkbox"/> <input type="checkbox"/> 24. Other psychiatric disorders <input type="checkbox"/> <input type="checkbox"/> 25. Eating disorder (anorexia/bulimia).... <input type="checkbox"/> <input type="checkbox"/> 26. Breast problems <input type="checkbox"/> <input type="checkbox"/> 27. Chlamydia..... <input type="checkbox"/> <input type="checkbox"/> 28. Gonorrhea <input type="checkbox"/> <input type="checkbox"/> 29. Herpes <input type="checkbox"/> <input type="checkbox"/> 30. Syphilis <input type="checkbox"/> <input type="checkbox"/> 31. Genital warts/HPV <input type="checkbox"/> <input type="checkbox"/> 32. Vaginal yeast infection <input type="checkbox"/> <input type="checkbox"/> 33. Bacterial vaginosis (BV) <input type="checkbox"/> <input type="checkbox"/> 34. Trichomonas..... <input type="checkbox"/> <input type="checkbox"/> 35. Pelvic infections..... <input type="checkbox"/> <input type="checkbox"/> 36. Sexual abuse/assault/incest..... <input type="checkbox"/> <input type="checkbox"/> 37. Physical abuse/assault..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> NO KNOWN MEDICAL PROBLEMS			LIFESTYLE (<i>Check all that apply</i>) 44. Alcohol <input type="checkbox"/> None <input type="checkbox"/> Yes - type & amount per week _____ 45. Tobacco <input type="checkbox"/> None <input type="checkbox"/> Yes - type & amount per day _____ Age started: _____ years old Quit Date _____ 46. Caffeine drinks <input type="checkbox"/> None <input type="checkbox"/> Yes - amount per day _____ 47. Street drugs <input type="checkbox"/> None <input type="checkbox"/> Yes - type & amount _____ 48. Do you exercise regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes - type & amount _____ 49. Do you practice SBE (Self breast examination)? <input type="checkbox"/> No <input type="checkbox"/> Yes 50. Do you take calcium and/or have adequate calcium in your diet? <input type="checkbox"/> No <input type="checkbox"/> Yes 51. Have you <u>ever</u> had <u>any</u> sexual activity? <input type="checkbox"/> No <input type="checkbox"/> Skip to #62 <input type="checkbox"/> Yes - <i>answer all questions</i> 52. Do you have sex with: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both 53. Do you have: <input type="checkbox"/> Oral sex <input type="checkbox"/> Anal sex <input type="checkbox"/> Vaginal intercourse 54. How old were you when you first had any kind of sex? _____ years old 55. About how many sexual partners have you had? _____ 56. Is sex painful for you? <input type="checkbox"/> No <input type="checkbox"/> Yes 57. Do you practice safer sex? <input type="checkbox"/> No <input type="checkbox"/> Yes 58. Do you practice withdrawal (he pulls out) without any contraception? <input type="checkbox"/> No <input type="checkbox"/> Yes 59. Have you had a new sexual partner in the last 3 months? <input type="checkbox"/> No <input type="checkbox"/> Yes 60. When was your last sexual contact or intercourse? _____ 61. Are you in a relationship where you feel threatened? <input type="checkbox"/> No <input type="checkbox"/> Yes 62. First day of last period ____/____/____		
			63. MENSTRUAL HISTORY: (Before you started using Birth Control) Age at first period: _____ years old. Number of days between periods: _____ days Length of periods: _____ days Problems: <input type="checkbox"/> Heavy bleeding <input type="checkbox"/> Long periods <input type="checkbox"/> Significant pain <input type="checkbox"/> Irregular cycles		
			64. PRESENT SYMPTOMS: Do you have any vaginal symptoms now? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unusual discharge <input type="checkbox"/> Itching <input type="checkbox"/> Burning <input type="checkbox"/> Pain <input type="checkbox"/> Foul Odor <input type="checkbox"/> Other _____		
			65. Do you have any concerns or want to talk about anything else? <input type="checkbox"/> No <input type="checkbox"/> Yes 66. Do you wish to have a chaperone in the room with you? <input type="checkbox"/> No <input type="checkbox"/> Yes		
			Patient Signature _____		
			<i>This area for health care provider use only.</i>		
			38. HOSPITALIZATIONS/SURGERIES: _____ _____ _____ _____		
			39. PREGNANCY HISTORY: <input type="checkbox"/> Never Pregnant # Pregnancies _____ # Deliveries _____ # Living children _____ # Miscarriages _____ # Abortion _____		
			Clinician Signature _____		