University of Connecticut Student Health Service, Storrs CT

Women's Clinic Health History

PATIENT NAME (PLEASE PRINT)				TODAY'S DATE AND TIME
PS#	**DATE OF BIRTH**	**AGE**	**Semester Status**	**Cell Phone**
School Address				**School Phone**
Home Address				**Home Phone**

1. ALLERGIES *(Medications, foods, latex, etc)*
☐None ☐Yes (Please list)

2. MEDICATIONS: *(Include birth control pills, herbal/vitamin/nutritional supplements)*

MEDICAL/GYN HISTORY (CHECK APPROPRIATE BOX)
FAMILY MEANS Mother Father Sister Brother
☐ **Adopted - family history not known**

Have you or family members had	YOU	FAMILY
3.High cholesterol	☐	☐
4.Heart disease	☐	☐
5.Rheumatic fever or heart murmur	☐	
6.High blood pressure	☐	☐
7.Blood clots	☐	☐
8.Asthma	☐	
9.Diabetes	☐	☐
10.Thyroid disease	☐	☐
11.Liver disease	☐	
12.Hepatitis	☐	☐
13.Anemia or blood diseases	☐	
14.Blood transfusion	☐	
15.Stomach/bowel/gallbladder disease	☐	
16.Kidney or bladder problems/UTI	☐	
17.HIV or AIDS	☐	☐
18.Mononucleosis	☐	
19.Cancer	☐	☐
20.Birth defects or inherited disease	☐	
21.Epilepsy or convulsions	☐	
22.Migraines	☐	☐
23.Depression	☐	☐
24.Other psychiatric disorders	☐	☐
25.Eating disorder (anorexia/bulimia)	☐	
26.Breast problems	☐	☐
27.Chlamydia	☐	
28.Gonorrhea	☐	
29.Herpes	☐	
30.Syphilis	☐	
31.Genital warts/HPV	☐	
32.Vaginal yeast infection	☐	
33.Bacterial vaginosis (BV)	☐	
34.Trichomonas	☐	
35.Pelvic infections	☐	
36.Sexual abuse/assault/incest	☐	
37.Physical abuse/assault	☐	

☐ **NO KNOWN MEDICAL PROBLEMS**

38. HOSPITALIZATIONS/SURGERIES:
_____
_____
_____
_____
_____
_____

39.PREGNANCY HISTORY:☐ Never Pregnant
Pregnancies _____ # Deliveries _____
Living children_____ # Miscarriages _____
Abortion _____

PAP TEST HISTORY
40. Have you ever had a regular GYN exam? ☐No ☐Yes Date of last exam _____
41. Have you ever had a PAP test? ☐No ☐Yes Date of last test _____
42. Have you ever been evaluated or treated for an abnormal PAP test? ☐No ☐Yes

43. **CONTRACEPTION HISTORY** *(Check all that apply)* ☐ Not Applicable
☐Birth control pills ☐Abstinence ☐Condoms ☐Spermicides ☐Diaphragm ☐Sponge
Name of Pill(s) _____ ☐IUD Type & date inserted _____
Dates used Pill _____ ☐OrthoEvra _____
☐Depo Provera ☐Nuva Ring _____
Date started _____ ☐Plan B last used_____
Date Last Shot _____
☐Sterilization

LIFESTYLE (*Check all that apply*)
44.Alcohol ☐ None ☐ Yes, type & amount per week _____
45.Tobacco ☐ None ☐ Yes, type & amount per day _____
Age started _____years old Quit Date _____
46.Caffeine drinks ☐ None ☐ Yes, amount per day _____
47.Street drugs ☐ None ☐ Yes, type & amount _____
48.Do you exercise regularly? ☐ No ☐ Yes, type & amount _____
49.Do you practice SBE (Self breast examination)? ☐No ☐ Yes
50.Do you take calcium and/or have adequate calcium in your diet? ☐No ☐ Yes
51.Have you ever had any sexual activity? ☐ No skip to # 62 ☐Yes, ***answer all questions***
52.Do you have sex with ☐ Men ☐ Women ☐ Both
53.Do you have ☐ Oral sex ☐ Anal sex ☐ 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? ☐ No ☐ Yes
57.Do you practice safer sex? ☐ No ☐ Yes
58.Do you practice withdrawal (he pulls out) without any contraception? ☐ No ☐ Yes
59.Have you had a new sexual partner in the last 3 months? ☐ No ☐ Yes
60.When was your last sexual contact or intercourse? _____
61.Are you in a relationship where you feel threatened?☐ No ☐ 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:☐ Heavy bleeding ☐ Long periods ☐ Significant pain ☐ Irregular cycles

64. PRESENT SYMPTOMS: Do you have any vaginal symptoms now? ☐ No ☐ Yes
☐ Unusual discharge ☐ Itching ☐ Burning ☐ Pain ☐ Foul Odor ☐ Other _____

65. Do you have any concerns or want to talk about anything else? ☐ No ☐ Yes
66. Do you wish to have a chaperone in the room with you? ☐ No ☐ Yes

Patient Signature _____

This area for health care provider use only.

Clinician Signature_____