

D. MENSTRUAL HISTORY

Age when period first started: _____
Day your most recent period began: ____/____/____
Was it normal? Yes No
Number of pads/tampons used on heaviest day? _____
Do you experience any of the following before or during your periods:
Cramps Bloating Bowel problems Emotional changes
Periods come every _____ days. Bleeding lasts ____ days.

Yes No
Are your periods usually regular?
Do you have bleeding between your periods?
Do you have bleeding after sex?

E. GYN / SEXUAL HISTORY

Yes No
Have you ever been sexually active?
If yes: Age at first intercourse? _____
Do you have (check all that apply): Vaginal sex? Oral sex?
Anal sex?
Sexual Partner(s): Male Female Both
Total number of lifetime partners: _____
Number of partners in the past year: ____ Male ____ Female
Number of partners in the past 90 days: ____ Male ____ Female
Does your partner(s) have sex with: Male Female Both
Do you use a barrier method (e.g. condoms, dental dams):
 Always Sometimes Never
Were any of your partners:
 A street drug user A hemophiliac Infected with HIV/AIDS
 Do you have any questions/concerns about sex?
 Have you ever had a Pap smear?
If yes: When was your last Pap smear? _____
Have you ever had an abnormal Pap smear:
 No Yes, date: _____ result: _____
 Treatment to Cervix: LEEP/laser/cryotherapy/cone?
Do you perform monthly breast self-exams?
 Have you ever had a mammogram? Most recent date: _____

Have you ever had the following? No **If yes,** check below:
 HPV/Warts Herpes Trichomonas
 Chlamydia HIV / AIDS Molluscum
 Gonorrhea Syphilis Bacterial vaginosis (BV)

F. CONTRACEPTIVE HISTORY

Do you want a birth control method today? Yes No
If yes, what method? _____
Check ALL Contraceptive Methods you have ever used:

Now	Past	Now	Past
<input type="checkbox"/> Pill (type) _____	<input type="checkbox"/> Depo Provera (shot)	<input type="checkbox"/> Diaphragm	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Lunelle (shot)	<input type="checkbox"/> Evra Patch	<input type="checkbox"/> Vasectomy	<input type="checkbox"/> Vaginal Ring (NuvaRing)
<input type="checkbox"/> Condom	<input type="checkbox"/> Withdrawal	<input type="checkbox"/> Rhythm/Natural	<input type="checkbox"/> Cervical cap
<input type="checkbox"/> Abstinence	<input type="checkbox"/> Norplant	<input type="checkbox"/> Female condom	<input type="checkbox"/> Foam/sponge/film
<input type="checkbox"/> IUD (Brand used) _____			

Comments or problems with method(s): _____

G. PREGNANCY HISTORY

Yes No
Could you be pregnant now?
Are you planning a pregnancy in the next year?
Have you ever had difficulty getting pregnant?
Have you ever been pregnant? If NO, skip to SOCIAL HISTORY
Age at first pregnancy ____ Total # of pregnancies? ____
Number of Vaginal delivery(s) and Date(s) _____
Number of C-section(s) and Date(s) _____
Number of Miscarriage(s) and Date(s) _____
Number of Abortion(s) and Date(s) _____
Number of Ectopic(s) (tubal) and Date(s) _____
Number of Living children _____
Have you had any of the following problems with a pregnancy?
High blood pressure Genetic or birth defects

H. SOCIAL HISTORY / HEALTH HABITS

Yes No
Do you drink alcohol? # _____ drinks per week
Do you smoke? # _____ cigarettes per day
Do you use street drugs? What? _____
Do you want information to get help for alcohol/drug use?
Have you received blood products prior to 1978?
Have you ever shared needles? (e.g. injecting drugs, tattooing, piercing)
Have you been hit, hurt or made to feel afraid by an intimate partner, now or in the past?
Have you been a victim of sexual abuse or coercion?
Are you experiencing emotional or relationship problems?
Are you experiencing financial or employment problems?
I acknowledge that the above information is correct & complete. I understand that if any reportable disease is found it will be reported to the Health Department.
Patient Signature _____ Date _____

STAFF NOTES:

This Health History information, as supplied by the patient, was reviewed & verified by:
Clinician Signature _____ Date _____
Clinician Signature _____ Date _____
Clinician Signature _____ Date _____

Patient Label