



Patient Name \_\_\_\_\_

Acct # \_\_\_\_\_

**MENSTRUAL HISTORY**

Age when period first started: \_\_\_\_\_

Day your most recent period began: \_\_\_/\_\_\_/\_\_\_

Was it normal?  Yes  No \_\_\_\_\_

Periods are:  Regular  Irregular  Painful

Flow is:  Light  Moderate  Heavy

Periods come every \_\_\_ days. Bleeding lasts \_\_\_ days.

Yes No

Do you miss periods? If yes, how often? \_\_\_\_\_

Do you have bleeding between your periods?

Do you take medication for cramps? What? \_\_\_\_\_

**GYN / SEXUAL HISTORY**

Yes No

Have you ever had sexual intercourse?

If yes, Age at first intercourse? \_\_\_\_\_

Sexually Active  Anal  Oral  Vaginal

Sexual Partner(s)  Male  Female  Both

Had more than 1 sex partner in past year or a new partner?

Have you had 5 or more sex partners in your lifetime?

Do you use condoms with sex every time?

Do you have any Questions/concerns about sex?

Do you want testing for sexually transmitted infections?

Have you ever had an Abnormal pap smear?

Treatment to Cervix: LEEP/laser/cryotherapy/cone?

Uterine Fibroids or other uterine problems?

Breast discharge/ lumps/ surgery or other breast problems?

Pelvic inflammatory Disease (PID)?

Frequent diagnosed yeast infections?

**Have you ever had the following?**  No **If yes, check below:**

HPV/Warts  Herpes  Trichomonas

Chlamydia  HIV / AIDS  Molluscum

Gonorrhea  Syphilis  Bacterial vaginosis (BV)

**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

Pill \_\_\_\_\_

Now Past

Diaphragm

Depo Provera (shot)

Tubal Ligation

Lunelle (shot)

Vasectomy

Evra Patch

Vaginal Ring (NuvaRing)

Condom

Rhythm/Natural

Withdrawal

Cervical cap

Abstinence

Female condom

Norplant

Foam/sponge/film

IUD (Brand used) \_\_\_\_\_

Comments or problems with method(s): \_\_\_\_\_

**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/HEALTH HABITS

Age at first pregnancy \_\_\_\_\_ # of pregnancies? \_\_\_\_\_

Number of Live Births \_\_\_\_\_ Date(s) \_\_\_\_\_

Number of C-section(s) \_\_\_\_\_ Date(s) \_\_\_\_\_

Number of Premature birth \_\_\_\_\_ Date(s) \_\_\_\_\_

Number of Miscarriage(s) \_\_\_\_\_ Date(s) \_\_\_\_\_

Number of Stillbirth(s) \_\_\_\_\_ Date(s) \_\_\_\_\_

Number of Ectopic(s) (tubal) \_\_\_\_\_ Date(s) \_\_\_\_\_

Number of Abortion(s) \_\_\_\_\_ Date(s) \_\_\_\_\_

Number of Living children \_\_\_\_\_ Age(s) \_\_\_\_\_

**Have you had any of the following problems with a pregnancy?**

High blood pressure  Genetic or birth defects

**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?

Do you perform monthly breast self-exam?

Have you ever had a mammogram? \_\_\_\_\_

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?

**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**

Emergency instructions given (Form #115)

Teen counseling provided (if < age 18). Parental involvement \_\_\_\_\_

STI/HIV/Safer Sex/condom info discussed

Prophylactic ECPs discussed. ECPs requested / refused (#940) / undecided

Form #5: Medical consent /HIPAA Acknowledgement complete

Form 18: BCM consent signed \_\_\_\_\_

Requests to defer exam. Form #303 given/importance of exam stressed

Staff Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**This Health History information, as supplied by the patient, was reviewed & verified by:**

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_