PURCHASE COLLEGE HEALTH SERVICE - WOMEN'S HEALTH

Name:_____ Date: _____ Age: _____ CID #: _____

Have you ever had a gynecological exam? No ___ Yes ___Date of last exam_____
Date of last Pap smear _____ Results- Normal _____Abnormal_____
Have you had an abnormal Pap? No ____Yes____
If Yes, what follow up treatment was done?
_____

List any medications you are now taking:_____

Do you take a vitamin with Calcium ____Folic Acid ____ Iron___?
Do you take any other supplements or herbs? No ____Yes ___What_____
Do you have any **allergies** to medications? No ____Yes ____
Medication:_____Reaction:_____
Medication:_____Reaction:_____

MENSTRUAL HISTORY

Age of onset of first period_____
First day of last period (LMP)_____
Was it a "normal" period? _____
Average # of days of menstrual flow _____
How many days between periods? _____
Any bleeding between periods?_____
Do you get cramps? If so how do you treat them? _____
Have your periods changed in the last year? If so in what way? _____

SEXUAL/RELATIONSHIP HISTORY

Have you ever had sexual intercourse/relations? No___ Yes___
with: women ___men __both__
age at first sexual encounter? ____

Are you currently in a sexual relationship? No ___Yes___
with women ___men ___both___

With how many people are you currently having sex?___

Total number of sexual partners past and present? ____

Name: _____ CID #: _____

BIRTH CONTROL/PREGNANCY

My current method of birth control is _____N/A_____

Have you used other birth control methods in the past? No____ Yes_____
If yes: What _____When____
Why did you change? _____

Have you ever had a problem with a birth control method? No____ Yes____
If yes, please explain_____

Have you ever been pregnant? No ___ Yes ___
give dates: Live births _____ Miscarriage(s)_____ Induced Abortion _____Ectopic ___
any problems in pregnancy? Explain:_____

SEXUAL PRACTICES/STI (Sexually Transmitted Infection) HISTORY

If you have a male partner does he use condoms? Always ___Sometimes ___Never___

Have you ever performed oral sex? No ___Yes___
on: women __men __both___
do you take the semen(cum) into your mouth? No ___Yes__

Have you had oral sex performed on you? No ___Yes___
by: women __men ___both ___

Have you ever had receptive anal intercourse? No ___Yes___
(had a man's penis in your rectum?) did he wear a condom? No __ Yes ___

Do you have pain during or after sexual relations? No ___Yes___

Do you have bleeding during or after sexual relations? No ___Yes___

Have you ever used sex toys? No ___Yes___

Have you ever had an STI (sexually transmitted infection)? No ___ Yes ___ When ____
Which one(s)? Chlamydia __ Gonorrhea __
Syphilis __ PID(pelvic infl. disease) __
Herpes __ Genital Wart __ Molluscum __
HIV__ Other __

Were you ever given medication for an STI? No ___ Yes ___ name of drug _____

Was your sexual partner(s) treated also? No ___ Yes ___

Does your current sexual partner have symptoms or a diagnosis of an STI? No ___ Yes ___

Has your partner received treatment for it? No ___ Yes ___

Have you been tested for HIV? No ___ Yes ___ (+)___(-)___Date _____

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INTERPERSONAL RELATIONSHIPS HISTORY

What forms of intimacy are most important to you in your dating/ love relationships? Talking___ Hugging__ Cuddling__ Kissing___ Oral sex__ Intercourse__

Do you feel that there is an equal decision-making or power relationship between you and your partner? No ____Yes___

Have you been a victim of interpersonal violence in the form of physical, emotional and/or sexual abuse? No ___Yes___
(Abuse may mean being molested, assaulted, harassed, stalked, raped or beaten)

_____

_____

_____

NUTRITION/EXERCISE

Do you have any dietary preferences or restrictions? No __Yes __ What?_____
Do you have any food allergies or intolerances? No __Yes __ What?_____
Have you ever used diet pills or other supplements to lose weight? No __Yes __ When?_____
Have you ever used laxatives to lose weight? No __ Yes __ When?_____
Have you ever made yourself vomit after eating? No __ Yes __ When? _____
Do you exercise regularly? No __ Yes __ How Frequent? _____

SELF CARE	**no**	**yes**
Do you examine your breasts?	□	□
Do you douche?	□	□
Do you use deodorant tampons?	□	□
Do you use feminine hygiene sprays?	□	□
Do you smoke cigarettes?	□	□
Do you use alcohol?	□	□
Do you use other drugs?	□	□
Have you used a needle to inject drugs?	□	□
Have you ever had a tattoo or piercing?	□	□

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Name: _____ CID #:_____

MEDICAL/FAMILY HISTORY

	You	Family
Asthma	___	___
Anemia	___	___
Eating disorder	___	___
Depression/Anxiety	___	___
Headaches	___	___
High Blood Pressure	___	___
Heart Murmur	___	___
Heart Attack	___	___
Gastrointestinal problem	___	___
Kidney/Bladder infection	___	___
Diabetes	___	___
Blurry/Double Vision	___	___
Epilepsy/Seizures	___	___
Blood Clots	___	___
Varicose Veins	___	___
Pain, swelling of legs	___	___
Thyroid disorders	___	___
Breast Lumps	___	___
Cancer	___	___
Surgery	___	___
Other illness not listed	___	___

Do you have any other concerns today?_____
_____

Date: _____ Patient's Signature:_____

***For office use only*:**
History reviewed_____
Date next pap needed_____
Gyn exam recommended Yes ___ No___
STI& HIV risk reduction counseling done___

_____

_____

Date: _____ HCP Signature: _____