



WOMEN'S CLINIC HEALTH HISTORY FORM

Please circle your answers or fill in the blanks.

Today's date: _____

Name: _____

Date of Birth: _____

Student ID#: _____

Cell Phone Number: _____

Preferred Name: _____

Preferred Pronoun: _____

YOUR MEDICAL HISTORY: Please circle or list:

- | | |
|-----------------|---------------------------|
| Alcohol Abuse | Genital Warts |
| Asthma | Gonorrhea |
| Blood clots | High Blood Pressure |
| Breast Problems | Migraine Headaches |
| Chlamydia | Molluscum Contagiosum |
| Depression | Ovarian Cysts |
| Diabetes | Pelvic Inflammatory (PID) |
| Eating Disorder | Polycystic Ovaries (PCOS) |
| Endometriosis | Skin Cancer |
| Genital Herpes | Thyroid Disorder |

NONE OF THE ABOVE

Other: _____

YOUR MENSTRUAL HISTORY: Please circle & list:

First day of last menstrual period: ___/___/___

Age at onset of period: _____

Have you ever gone for months or years without having a period? Please circle: Yes No

YOUR PAP HISTORY: Please circle or list:

Have you had a pap before? Yes No

Have you had an **abnormal** pap before? Yes No

Date of abnormal pap if you've had one: _____

Result of abnormal pap: _____

YOUR PREGNANCY HISTORY: Please circle & list:

Have you ever been pregnant? Yes No

Number of pregnancies: _____

Number of live births: _____

YOUR SOCIAL HISTORY:

Do you vape, use JUUL, smoke cigarettes or marijuana, inhale Hooka or use smokeless tobacco products?

Yes No If yes, what and how often?

REASON FOR VISIT:

Annual Exam

Want Birth Control

Problem Exam

Other: _____

Please circle:

STD Testing

Birth Control Problems

Pregnancy Testing

ALLERGY HISTORY:

None known

Medication(s) _____

Please circle:

Latex

FAMILY HISTORY:

Adopted

Breast Cancer

Blood Clots

Cervical Cancer

Diabetes

NONE OF THE ABOVE

Other: _____

Please circle or list:

Endometriosis

Fibrocystic Breasts

Problems with birth control

Polycystic Ovaries (PCOS)

Thyroid Disease

CONTRACEPTIVE YOU ARE CURRENTLY USING:

Please circle:

NONE

Nexplanon

Ring

Patch

Depo

Condoms

Diaphragm

Rhythm

Surgical

IUD

Pill

MEDICATIONS YOU ARE TAKING NOW: circle **NONE**

Or please list **all** medications, supplements & birth control _____

HPV VACCINE HISTORY (Gardasil):

Please circle:

One, two, all 3

NONE

YOUR SEXUAL HISTORY:

Please circle:

Have you had intercourse?

Have you had oral sex?

Have you had skin to skin contact?

Gender of partners:

Total number of partners **ever**?

How long have you had your present partner?

Age at first intercourse?

Yes No

Yes No

Yes No

Male Female
