GYN HEALTH HISTORY - WESLEYAN HEALTH CENTER

The Health History is personal and confidential. Please feel free to leave questions blank if you are uncomfortable answering. Be prepared to discuss with clinician.

Preferred Name	**Legal Name**			**Pronoun**	**Date**
Wes ID #	**Date of Birth**	**Age**	**Semester Status**		
School Address				**School Phone**	**Cell Phone**
Home Address				**Home Phone**	**During Breaks**

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 IMMEDIATE FAMILY ONLY
☐ **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	☐	
17.HIV or AIDS	☐	☐
18.Mononucleosis	☐	
19.Cancer	☐	☐
20.Birth defects or inherited disease	☐	☐
21.Epilepsy or convulsions	☐	
22.Stroke	☐	☐
23.Migraines	☐	☐
24.Depression	☐	☐
25.Other psychiatric disorders	☐	☐
26.Eating disorder (anorexia/bulimia)	☐	
27.Breast problems	☐	☐
28.Chlamydia	☐	
29.Gonorrhea	☐	
30.Herpes	☐	
31.Syphilis	☐	
32.Genital wart virus	☐	
33.Vaginal yeast infection	☐	
34.Bacterial vaginosis (BV)	☐	
35.Trichomonas	☐	
36.Pelvic infections	☐	
37.Sexual abuse	☐	
38.Physical abuse/assault	☐	

☐ **NO KNOWN MEDICAL PROBLEMS**

39**. HOSPITALIZATIONS/SURGERIES**:
_____
_____
_____

40**. PREGNANCY HISTORY**:
Pregnancies _____ # Deliveries _____
Living children_____ # Miscarriages _____
Abortion _____

PAP TEST HISTORY
41. Have you ever had a regular GYN exam? ☐No ☐Yes Date of last exam _____
42. Have you ever had a PAP test? ☐No ☐Yes Date of last test _____
43. Have you ever had an abnormal PAP test? ☐No ☐Yes
44. If #43 Yes – Outcome or treatment for abnormal Pap _____

45. **CONTRACEPTION HISTORY** *(Check all that apply*) ☐ Not Applicable
☐ Abstinence
☐ Birth control pills/ Name of Pill(s) _____/ Dates used Pill _____
☐ Condoms
☐ Spermicides
☐ Diaphragm
☐ Ring
☐ Patch
☐ IUD Type & date inserted _____
☐ Depo Provera/Date started_____/Date last shot_____
☐ Withdrawal of penis (before ejaculation) without contraception
☐ Used Morning After Pill
Method now using _____/Method you would like now _____

LIFESTYLE (*Check all that apply*)
46.Alcohol ☐ None ☐ Yes, type & amount per week _____
47.Tobacco ☐ None ☐ Yes, type & amount per day _____
Age started _____years old
48.Caffeine drinks ☐ None ☐ Yes, amount per day _____
49.Street drugs ☐ None ☐ Yes, type & amount _____
50.Do you exercise regularly? ☐ No ☐ Yes, type & amount _____
51.Have you ever had any sexual activity? ☐ No skip to # 61 ☐Yes, ***answer all questions***
52.Partner(s) gender(s) _____
53.Do you have ☐ Oral sex ☐ Anal sex ☐ Vaginal intercourse sex
54.How old were you when you first had intercourse? _____years old
55.About how many sexual partners have you had this year? _____
56.Is sex painful for you? ☐ No ☐ Yes
57.Do you have bleeding with sexual activity/intercourse? ☐ No ☐ Yes
58.Do you practice safer sex? ☐ No ☐ Yes
59.When was your last sexual contact or intercourse? _____
60. When was your last STI screen? _____ What testing did you have done?
_____

61**. MENSTRUAL HISTORY: (Prior to contraceptive use)**
First day of last period ____/____/____
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
62.Approximately how many periods do you get a year? (not on contraceptives) _____

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

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

This area for health care provider use only.

Clinician Signature_____