

WHAT TO DO BEFORE YOU COME FOR GYNECOLOGICAL CARE

Please complete the enclosed or/online gynecological history form and bring it with you to your appointment. In order to make an accurate assessment of your health, it is necessary to ask personal and explicit questions. If you are uncomfortable with these questions, please do not feel obligated to answer. You can address them directly with your provider at your visit.

In order to get an accurate Pap smear it is important that you do a few things.

- Do not engage in intercourse without a condom for 24 hours before exam.
- If you douche, please do not do so for at least 3 days before exam.
- If you are menstruating, please reschedule your appointment UNLESS you are interested in starting oral contraceptives. In this circumstance, we will not perform the exam but it is an ideal time to start the pill.

TESTING

All testing can be charged to your student account and appears as "infirmery lab fee".

Or, if you prefer, please let us know and we can submit it to your private/or student insurance at the time of the exam. There are numerous private insurance companies and we are not familiar with all the details of coverage. It is your responsibility to find out whether your laboratory exam is covered and whether or not the billing is sent to your parents. This may or may not be an issue for you. It is helpful if you bring a current insurance card with you to your visit. We can provide you with an itemized statement for you to file an insurance claim. Please let us know.

FEES

- Pap smear is \$35.00. If the Pap is abnormal, there is an additional test performed for approximately \$60.00
- Chlamydia test \$25.00.
- Gonorrhea test \$25.00
- HIV test \$30.00
- Urinalysis \$9.00
- Vaginal smear \$5.00
- VDRL/RPR Syphilis \$13.00
- Lab processing fee per visit \$5.00

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
Date of Birth	Age	Semester Status	
School Address		School/Cell phone	
Address during breaks		Phone during breaks	

<p>1. ALLERGIES (<i>Medications, foods, latex, etc</i>) <input type="checkbox"/>None <input type="checkbox"/>Yes (Please list)</p> <hr/> <p>2. MEDICATIONS: (<i>Include birth control pills, herbal/vitamin/nutritional supplements</i>)</p> <hr/> <p>3. MEDICAL/GYN HISTORY - FAMILY MEANS IMMEDIATE FAMILY ONLY (Check appropriate box)</p> <p><input type="checkbox"/> Adopted – family history not known</p> <p>Have you or family member had:</p> <table style="width:100%; border: none;"> <thead> <tr> <th style="width:60%;"></th> <th style="width:20%; text-align: center;">YOU</th> <th style="width:20%; text-align: center;">FAMILY</th> </tr> </thead> <tbody> <tr><td>Heart disease</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>High blood pressure</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>High cholesterol</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Migraines</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Stroke</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Blood clots</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td colspan="3"> </td></tr> <tr><td>Anemia or blood disease</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Diabetes</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Thyroid disease</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Liver disease</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Mononucleosis</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Depression</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Eating disorder (anorexia/bulimia)</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Other psychiatric disorders</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Cancer</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Birth defects or Inherited disease</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Breast problems</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td></tr> <tr><td>Kidney or bladder problems</td><td align="center"><input type="checkbox"/></td><td></td></tr> <tr><td>HIV/AIDS</td><td align="center"><input type="checkbox"/></td><td></td></tr> <tr><td>Chlamydia</td><td align="center"><input type="checkbox"/></td><td></td></tr> <tr><td>Herpes</td><td align="center"><input type="checkbox"/></td><td></td></tr> <tr><td>Syphilis</td><td align="center"><input type="checkbox"/></td><td></td></tr> <tr><td>Genital wart virus (HPV)</td><td align="center"><input type="checkbox"/></td><td></td></tr> <tr><td>Vaginal yeast</td><td align="center"><input type="checkbox"/></td><td></td></tr> <tr><td>Bacterial vaginosis (BV)</td><td align="center"><input type="checkbox"/></td><td></td></tr> <tr><td>Trichomonas</td><td align="center"><input type="checkbox"/></td><td></td></tr> <tr><td>Pelvic infections</td><td align="center"><input type="checkbox"/></td><td></td></tr> <tr><td>Physical/sexual abuse</td><td align="center"><input type="checkbox"/></td><td></td></tr> </tbody> </table> <p><input type="checkbox"/> NO KNOW MEDICAL PROBLEMS</p> <p>HOSPITALIZATIONS/SURGERIES: _____ _____</p> <p>4. PREGNANCY HISTORY: # Pregnancies _____ # Deliveries _____ # Living Children _____ # Miscarriages _____ # Abortion _____</p>		YOU	FAMILY	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>				Anemia or blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder (anorexia/bulimia)	<input type="checkbox"/>	<input type="checkbox"/>	Other psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Birth defects or Inherited disease	<input type="checkbox"/>	<input type="checkbox"/>	Breast problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder problems	<input type="checkbox"/>		HIV/AIDS	<input type="checkbox"/>		Chlamydia	<input type="checkbox"/>		Herpes	<input type="checkbox"/>		Syphilis	<input type="checkbox"/>		Genital wart virus (HPV)	<input type="checkbox"/>		Vaginal yeast	<input type="checkbox"/>		Bacterial vaginosis (BV)	<input type="checkbox"/>		Trichomonas	<input type="checkbox"/>		Pelvic infections	<input type="checkbox"/>		Physical/sexual abuse	<input type="checkbox"/>		<p>5. PAP TEST HISTORY Have you ever had a regular GYN exam? <input type="checkbox"/>No <input type="checkbox"/>Yes, Date of last exam _____ Have you ever had a PAP test? <input type="checkbox"/>No <input type="checkbox"/>Yes, Date of last test _____ Have you ever had an abnormal PAP test? <input type="checkbox"/>No <input type="checkbox"/>Yes, If abnormal PAP, outcome _____</p> <p>Have you ever had Gardasil vaccine? <input type="checkbox"/>No <input type="checkbox"/>Yes Date #1 ____ Date #2 ____ Date#3 ____</p> <p>6. CONTRACEPTION HISTORY (<i>Check all that apply</i>) <input type="checkbox"/>Not Applicable <input type="checkbox"/>Abstinence <input type="checkbox"/>Birth control pills/ Name of Pill(s) _____ / Dates used Pill _____ <input type="checkbox"/>Condoms <input type="checkbox"/>Spermicides <input type="checkbox"/>Diaphragm <input type="checkbox"/>Ring <input type="checkbox"/>Patch <input type="checkbox"/>IUD Type & date inserted _____ <input type="checkbox"/>Depo Provera/Date started _____/Date last shot _____ <input type="checkbox"/>Withdrawal of penis (before ejaculation) without contraception <input type="checkbox"/>Used Morning After Pill <input type="checkbox"/>Method now using _____/Method you would like now _____</p> <p>7. LIFESTYLE (<i>Check all that apply</i>) Alcohol <input type="checkbox"/>None <input type="checkbox"/>Yes, type & amount per week _____ Tobacco <input type="checkbox"/>None <input type="checkbox"/>Yes, type & amount per day _____ Caffeine drinks <input type="checkbox"/>None <input type="checkbox"/>Yes, type & amount per day _____ Street drugs <input type="checkbox"/>None <input type="checkbox"/>Yes, type & amount _____ Do you exercise regularly? <input type="checkbox"/>No <input type="checkbox"/>Yes, type and amount _____</p> <p>Have you <u>ever</u> had <u>any</u> sexual activity? <input type="checkbox"/>Yes, <i>answer all questions below</i> <input type="checkbox"/>No, skip to 8.</p> <p>Partner(s) gender(s) _____</p> <p>Have you had <input type="checkbox"/>Oral sex <input type="checkbox"/>Anal sex <input type="checkbox"/>Vaginal intercourse sex</p> <p>How old were you when you first had intercourse? _____ years old</p> <p>About how many sexual partners have you had in past year? _____</p> <p>Is sex painful for you? <input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p>Do you have bleeding with sexual activity/intercourse? <input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p>Do you practice safer sex? <input type="checkbox"/>No <input type="checkbox"/>Yes</p> <p>When was your last sexual contact or intercourse? _____</p> <p>When was your last STI screen? _____ What testing did you have done? _____ _____</p> <p>Clinician reviewed _____ initials / date</p>
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8. MENSTRUAL HISTORY: Are you on hormones/contraception now? No Yes _____

Age at first period: _____ years old.

Number of days between periods: _____ days. (beginning to beginning)

Length of periods: _____ days

Problems: Heavy bleeding Long periods Significant pain Irregular cycles

Approximately how many periods do you get a year? _____ (not on hormones/contraception)

DATE Last Menstrual Period began _____

9. PRESENT SYMPTOMS: Do you have any vaginal symptoms now? No Yes _____

Unusual discharge Itching Burning Pain Foul Odor Other _____

Do you have any urinary tract symptoms now? No Yes _____

Do you have any concerns or want to talk about anything else? No Yes _____

Would you like to have a chaperone in the room with you? No Yes

T **BP** **Wt** **Ht** **Date** _____

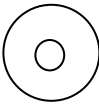
U/A / UCG _____

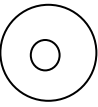
Primary Reason for Visit: _____

NI.	Var.	NE	NI.	Var.	NE	NI.	Var.	NE	NI.	Var.	NE	NI.	Var.	NE						
SKIN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	NECK	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	LUNGS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	HEART	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	LYMPH NODES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HEENT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	THYROID	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CHEST	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ABDOMEN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EXTREMITIES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

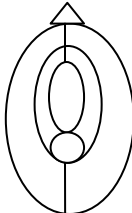
O: Exam:

Breasts:

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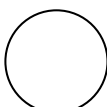
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External Genitalia:



Vagina:

Cervix:



Uterus/Adnexa:

Recto-vaginal:

A: Assessment:

Plan: Pap / HPV testing
Chlamydia / Gonorrhea
VDRL
HSV / typing
HIV / personal health
Wet smear

Education:
SBE
Contraception Risk / Use / Benefit
Gardasil Vaccine
STI / Safer Sex

Rx:

RTC:

Clinician's signature: _____

Revised 5/10