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 “infirmary lab fee”.

Or, if you prefer, please let us known 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 $84.20. An additional fee applied for HPV typing if abnormalities are detected.
- Chlamydia test $38.25
- Gonorrhea test $38.25
- HIV Blood Test $33.18
- Urinalysis $9.00
- Vaginal smear $5.00
- VDRL/RPR Syphilis $14.72
- Lab processing fee $10.00

01/23

HEALTH HISTORY – WESLEYAN HEALTH CENTER (For Bodies with a Vagina)

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**	

1. ALLERGIES (*Medications, foods, latex, etc)*
❑None ❑Yes (Please list)

2. MEDICATIONS: (*Include birth control pills, herbal/vitamin/nutritional supplements)*

3. MEDICAL/GYN HISTORY - FAMILY MEANS IMMEDIATE FAMILY ONLY
(Check appropriate box)

❑ **Adopted – family history not known**

Have you or family member had:

	YOU	FAMILY
Heart disease	❑	❑
High blood pressure	❑	❑
High cholesterol	❑	❑
Migraines	❑	❑
Stroke	❑	❑
Blood clots	❑	❑
Anemia or blood disease	❑	❑
Diabetes	❑	❑
Thyroid disease	❑	❑
Liver disease	❑	❑
Mononucleosis	❑	❑
Depression	❑	❑
Eating disorder (anorexia/bulimia)	❑	❑
Other psychiatric disorders	❑	❑
Cancer	❑	❑
Birth defects or Inherited disease	❑	❑
Breast problems	❑	❑
Kidney or bladder problems	❑	❑
HIV/AIDS	❑	❑
Chlamydia	❑	❑
Gonorrhea	❑	❑
Herpes	❑	❑
Syphilis	❑	❑
Genital wart virus (HPV)	❑	❑
Vaginal yeast	❑	❑
Bacterial vaginosis (BV)	❑	❑
Trichomonas	❑	❑
Pelvic infections	❑	❑
Physical/sexual abuse	❑	❑

❑ **NO KNOW MEDICAL PROBLEMS**

HOSPITALIZATIONS/SURGERIES:

_____

_____

4. PREGNANCY HISTORY:
Pregnancies _____ # Deliveries _____
Living Children ____ # Miscarriages _____
Abortion _____

5. PAP TEST HISTORY
Have you ever had a regular GYN exam? ❑No ❑Yes, Date of last exam _____
Have you ever had a PAP test? ❑No ❑Yes, Date of last test _____
Have you ever had an abnormal PAP test? ❑No ❑Yes, If abnormal PAP, outcome

Have you ever had HPV vaccine? ❑No ❑Yes #1 ____ #2 ____ #3____

6. CONTRACEPTION HISTORY (*Check all that apply)* ❑Not Applicable
❑Abstinence
❑Birth control pills/ Name of Pill(s) _____/ Dates used Pill _____
❑Condoms
❑Spermicides
❑Diaphragm
❑Implanon
❑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 _____

7. LIFESTYLE (*Check all that apply)*
Alcohol ❑None ❑Yes, type & amount per week _____
Tobacco ❑None ❑Yes, type & amount per day _____
Caffeine drinks ❑None ❑Yes, type & amount per day _____
Street drugs ❑None ❑Yes, type & amount _____
Do you exercise regularly? ❑No ❑Yes, type and amount _____

Have you ever had any sexual activity? ❑Yes, *answer all questions* below ❑**No, skip to 8.**

Partner(s) gender(s) _____

Have you had ❑Oral sex ❑Anal sex ❑Vaginal intercourse sex

How old were you when you first had intercourse? _____years old

About how many sexual partners have you had in past 12 months?_____

Is sex painful for you? ❑No ❑Yes

Do you have bleeding with sexual activity/intercourse? ❑No ❑Yes

Have you had sex outside of the United States? ❑No ❑Yes

Partner with past/current STI? ❑No ❑Yes

Do you practice safer sex? ❑No ❑Yes

Have you ever paid or been paid for sex? ❑No ❑Yes

When was your last sexual contact or intercourse? _____

When was your last STI screen? _____ What testing did you have done?

_____

Name _____ **DOB** _____

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

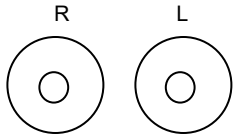
T BP Wt Ht Date

U/A / UCG _____

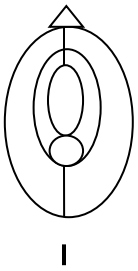
Primary Reason for Visit: _____

	Nl.	Var.	NE		Nl.	Var.	NE		Nl	. Var.	NE		Nl.	Var.	NE		Nl.	Var.	NE
SKIN	O	O	O	NECK	O	O	O	LUNGS	O	O	O	HEART	O	O	O	LYMPH NODES	O	O	O
HEENT	O	O	O	THYROID	O	O	O	CHEST	O	O	O	ABDOMEN	O	O	O	EXTREMITIES	O	O	O

O: Exam:
Breasts:

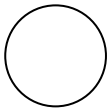


External Genitalia:



Vagina:

Cervix:



Uterus/Adnexa:

Recto-vaginal:

A: Assessment:

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

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

Rx:

RTC:

Clinician's signature: _____

Revised 08/18