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 $78.69. An additional fee applied for HPV typing if abnormalities are detected.
- Chlamydia test $35.75
- Gonorrhea test $35.75
- HIV Blood Test 10-day turn around $31.01
- Urinalysis $9.00
- Vaginal smear $5.00
- VDRL/RPR Syphilis $13.58
- Lab processing fee $10.00

08/21
# 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.

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<tr>
<th>Preferred Name</th>
<th>Legal Name</th>
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<tr>
<td>Date of Birth</td>
<td>Age</td>
<td>Semester Status</td>
<td>School/Cell phone</td>
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<td>Address during breaks</td>
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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

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) ______ Date 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? ______

HOSPITALIZATIONS/SURGERIES: ________
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: _________________________________________________________________________

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O: Exam:
Breasts:

R
L

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