AMERICAN UNIVERSITY STUDENT HEALTH CENTER

WOMEN'S HEALTH HISTORY - General

Student ID # _____ Date of Birth ___/___/___

(Print Name) Last, First _____ Age _____

Please answer all questions

What is the reason for your visit today?
When was the first day of your last menstrual period?
Are your periods regular?
How often do you have a period?
How long do your periods last?
Are your periods painful?
Have you ever had a gynecological exam?
What was the date and result of your most recent PAP smear?
If you've had an abnormal PAP smear please give the date and details.

Please answer all questions			**Detail all Yes responses**
• Do you have any health problems?	N ☐	Y ☐	
• Are you currently under a provider's care?	N ☐	Y ☐	
• Have you ever had an overnight hospital stay?	N ☐	Y ☐	
• Do you take any daily or intermittent medications, including birth control pills?	N ☐	Y ☐	
• Do you take any over the counter medications, vitamins, or herbal supplements?	N ☐	Y ☐	
• Are you allergic to any medications?	N ☐	Y ☐	
• Have you ever had surgery other than dental surgery?	N ☐	Y ☐	
• Do you smoke? If yes, how many cigarettes per day?	N ☐	Y ☐	
• Do you use alcohol? If yes, how many drinks in a 7 day week?	N ☐	Y ☐	
• Do you do monthly self-breast exams?	N ☐	Y ☐	

Sexual History	**Detail all Yes responses**
Are you sexually active? ☐ N ☐ Y	
Do you have more than one (1) sexual partner? ☐ N ☐ Y	If yes, how many?
Have you had more than one (1) sexual partner? ☐ N ☐ Y	If yes, how many?
What type of intercourse do you engage in : ☐ oral ☐ vaginal ☐ anal	
Partner (s): ☐ male ☐ female ☐ both	
Have you ever had a sexually transmitted infection? ☐ N ☐ Y	
Has your partner ever had a sexually transmitted infection? ☐ N ☐ Y	
Do you use any form of contraception? ☐ N ☐ Y	
Have you ever been pregnant? ☐ N ☐ Y	
Have you ever terminated a pregnancy? ☐ N ☐ Y	
Have you ever been physically or emotionally abused? ☐ N ☐ Y	
Has anyone ever forced you into sexual activities? ☐ N ☐ Y	
Are you afraid of your partner or anyone else? ☐ N ☐ Y	

(OVER)

FAMILY HISTORY

Please check if any blood relatives (parents, grandparents, siblings, aunts, uncles) have, or have had:

	Heart disease		Diabetes		High cholesterol
	High blood pressure		Cancer		Bleeding/Clotting Disorder
	Breast/Ovarian/Uterine/Cervical Cancer (please circle)		Other		

WOMEN'S HEALTH HISTORY

DO YOU NOW, OR DID YOU EVER HAVE:

	NO	YES	DATE
Blood Disorder			
Liver Disease			
Cancer			
Stroke or Heart Disease			
Migraine Headaches			
High blood Pressure			
Gallbladder Disease			
Diabetes			
Epilepsy			
Asthma			
Pelvic Inflammatory Disease			
Kidney Disease			
Sickle Cell Disease			
Breast Lump			
Psychological Problems			
Any chronic diseases			
Recent exposure to Sexually Transmitted Infection			

ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS?

	NO	YES
Abnormal Vaginal Discharge		
Pain during intercourse		
Fever		
Chills		
Pelvic pain		
Burning on urination		
Genital Sores		
Vaginal Odor		
Abnormal Vaginal Bleeding		