

**PACIFIC UNIVERSITY STUDENT HEALTH SERVICES**

2043 COLLEGE WAY, FOREST GROVE, OR 97116

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**Woman's History Form**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICAL HISTORY**

Have you ever had the following:

- allergies – explain \_\_\_\_\_
- anemia
- arthritis
- asthma
- cancer - type \_\_\_\_\_
- depression
- eating disorder
- diabetes
- seizure disorder
- elevated blood pressure
- migraine headaches
- thyroid problems
- blood clots or clotting disorder

Do you (check all that apply):

- smoke \_\_\_\_\_
- exercise regularly \_\_\_\_\_
- consume caffeine \_\_\_\_\_
- drink alcohol \_\_\_\_\_
- do self breast exam \_\_\_\_\_
- use drugs \_\_\_\_\_

List all current medications: \_\_\_\_\_

Hospitalizations / Surgeries: \_\_\_\_\_

Other concerns \_\_\_\_\_

Have you ever had an unwanted sexual experience?  
\_\_\_\_\_ yes \_\_\_\_\_ no

**GYNECOLOGICAL HISTORY** – date of last complete gyn. exam / pap \_\_\_\_\_

first day of last period \_\_\_\_\_

age periods began \_\_\_\_\_

flow: # days \_\_\_\_\_ heavy/med/light (circle one)

period about once a month?  yes  no

bleeding between periods?  yes  no

age at first intercourse? \_\_\_\_\_

# of pregnancies? \_\_\_\_\_

# of miscarriage / abortion \_\_\_\_\_

# of children / ages \_\_\_\_\_

pregnant now?  yes  no

Have you ever had the following?:

- yes  no ovarian cysts
- yes  no bladder infection
- yes  no more than 3 months between periods
- yes  no mammogram – when \_\_\_\_\_
- yes  no breast lump – when \_\_\_\_\_

Total # lifetime sexual partners? \_\_\_\_\_

Length of time with current partner: \_\_\_\_\_

Do you prefer sex with  male  female  both

Have you ever had any of the following?:

- genital warts, HPV
- chlamydia
- gonorrhea
- herpes
- syphilis
- yeast / BV / trichomoniasis
- PID
- abnormal pap \_\_\_\_\_

Do you have any of these risk factors? (check all that apply):

- new partner(s) since last exam
- IV drug use
- sex with a bisexual
- forced sex

Have any of your partners had the above risk factors?  yes  no

**BIRTH CONTROL** (circle methods used in the past):

pill \_\_\_\_\_ emergency contraception

condoms diaphragm cervical cap

IUD spermicide Depo Provera

Lunelle withdrawal abstinence

sterilization other \_\_\_\_\_

Currently using what method? \_\_\_\_\_

Method(s) desired? \_\_\_\_\_

Problems with methods in the past? \_\_\_\_\_

How often do you use condoms?:

always  often  sometimes  never

**FAMILY HISTORY:**

Are you adopted? \_\_\_\_\_  cancer \_\_\_\_\_

clotting disorder \_\_\_\_\_  migraine headache \_\_\_\_\_

heart attack/stroke/high blood pressure (before age 50) \_\_\_\_\_

thyroid problem \_\_\_\_\_  other \_\_\_\_\_

**MAIN CONCERN TODAY:** \_\_\_\_\_

DATE: \_\_\_\_\_ REVIEWED BY: \_\_\_\_\_