

Schiffert Health Center at Virginia Tech
WOMEN'S CLINIC HISTORY FORM

Name: _____

Date of Birth: _____

Student ID#: _____

Cell Phone Number: _____

Nickname: _____

E-mail Address: _____

REASON FOR VISIT

- Annual Exam Pregnancy Testing
- Problem Exam _____
- Pap Only STD Testing

MARITAL STATUS

- Single none known Latex
- Married Drugs _____
- Divorced _____

ALLERGIES

YOUR MEDICAL HISTORY - Check any for which you have been diagnosed or treated.

- | | |
|--|--|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Breast Problems | <input type="checkbox"/> Molluscum Contagiosum |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Genital Warts | <input type="checkbox"/> <u>NONE</u> |

FAMILY HISTORY - Check any that apply to family member(s).

- | | |
|--|--|
| <input type="checkbox"/> Adopted | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Fibrocystic Breasts |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Problems with Birth Control |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Other: | <input type="checkbox"/> <u>NONE KNOWN</u> |

Have you had HPV Vaccine (Gardasil)?
no | Yes, all three | Two of three | One only

Have you taken the Women's Clinic Health Course?
yes | no

YOUR MENSTRUAL HISTORY

First Day of Your Last Period (mm-dd-yyyy) ___ - ___ - ___

Age of Onset of Period ___ Years old

Have you ever gone for months or years
 without having a period? yes | no

What **medications** (birth control, vitamins, supplements, etc.) do you take?

None **or**

Names of medications _____

YOUR PAP HISTORY

Have you ever had a pap test before? yes | no

Had an abnormal pap? yes | no

Date of **abnormal** pap if you've had one: ___/___/___

Result _____

YOUR SEXUAL HISTORY

I have not had intercourse, oral sex, or skin to skin contact

I have had intercourse, oral sex, or skin to skin contact

Gender of Partner(s) male | female

Total number of partners _____

How long have you had your present partner? _____

Age at first intercourse _____

YOUR PREGNANCY/CONTRACEPTION HISTORY

Have you ever been pregnant? yes | no

Number of pregnancies: _____

Number of live births: _____

Check the contraceptive method(s) you currently use:

<input type="checkbox"/> None	<input type="checkbox"/> Patch	<input type="checkbox"/> Diaphragm
<input type="checkbox"/> Pill	<input type="checkbox"/> Depo	<input type="checkbox"/> Rhythm
<input type="checkbox"/> Ring	<input type="checkbox"/> Condoms	<input type="checkbox"/> Surgical

Are you happy with your present method? yes | no

YOUR SOCIAL HISTORY

Do you smoke? yes | no

If yes,

How much? _____