Schiffert Health Center at Virginia Tech

Women's Clinic Health History Form

Please circle your answers or fill in the blanks.

Today's date: _____
Name: _____
Date of Birth: _____
Student ID#: _____

Cell Phone Number: _____
Preferred Name: _____
Preferred Pronoun: _____

YOUR MEDICAL HISTORY: Please circle or list:

Alcohol Abuse	Genital Warts
Asthma	Gonorrhea
Blood clots	High Blood Pressure
Breast Problems	Migraine Headaches
Chlamydia	Molluscum Contagiosum
Depression	Ovarian Cysts
Diabetes	Pelvic Inflammatory (PID)
Eating Disorder	Polycystic Ovaries (PCOS)
Endometriosis	Skin Cancer
Genital Herpes	Thyroid Disorder

NONE OF THE ABOVE

Other: _____

YOUR MENSTRUAL HISTORY: Please circle & list:

First day of last menstrual period: ___/___/_____
Age at onset of period _____
Have you ever gone for months or years without having a period? Please circle: Yes No

YOUR PAP HISTORY: Please circle or list:

Have you had a pap before? Yes No
Have you had an **abnormal** pap before? Yes No
Date of abnormal pap if you've had one: _____
Result of abnormal pap: _____

YOUR PREGNANCY HISTORY: Please circle & list:

Have you ever been pregnant? Yes No
Number of pregnancies: _____
Number of live births: _____

YOUR SOCIAL HISTORY:

Do you smoke? Yes No
If yes, how much? _____
If yes, what do you smoke? _____

REASON FOR VISIT: Please circle:

Annual Exam	STD Testing
Want Birth Control	Birth Control Problems
Problem Exam	Pregnancy Testing

Other: _____

ALLERGY HISTORY: Please circle:

None known Latex
Medication(s) _____

FAMILY HISTORY: Please circle or list:

Adopted	Endometriosis
Breast Cancer	Fibrocystic Breasts
Blood Clots	Problems with birth control
Cervical Cancer	Polycystic Ovaries (PCOS)
Diabetes	Thyroid Disease

NONE OF THE ABOVE

Other: _____

CONTRACEPTIVE YOU ARE CURRENTLY USING:

Please circle:

NONE	Patch	Diaphram	IUD
Nexplanon	Depo	Rhythm	Pill
Ring	Condoms	Surgical	

MEDICATIONS YOU ARE TAKING NOW: circle *NONE*

Or please list **all** medications, supplements & birth control_____
_____
_____

HPV VACCINE HISTORY: Please circle:

One, two, all 3 **NONE**

YOUR SEXUAL HISTORY: Please circle:

Have you had intercourse?	Yes	No
Have you had oral sex?	Yes	No
Have you had skin to skin contact?	Yes	No
Gender of partners:	Male	Female

Total number of partners? _____
How long have you had your present partner? _____
Age at first intercourse? _____

Signature: _____