

Arcadia University
Student Health Services
Women's Health History Form

Name _____ Date _____ Age _____ D.O.B. _____
 Social Security Number _____ Local Telephone Number _____
 School Year Fr So Jr Sr Grad ALA (circle one) Single ___ Married ___ Divorced ___ Widowed ___
 Allergies _____ Current Medications _____

Past/Present Personal Medical/Surgical History (check any that apply)

<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Liver disease/hepatitis <input type="checkbox"/> Acne <input type="checkbox"/> Gall Bladder disease <input type="checkbox"/> Blood clots/phlebitis <input type="checkbox"/> Kidney/bladder disorder <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Brain Aneurysm/stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> High cholesterol <input type="checkbox"/> Psychiatric/emotional disorder <input type="checkbox"/> Eating Disorder	<p style="text-align: center;">Clinician's Notes</p>
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Family History (Parents, Grandparents, Brothers & Sisters)

<input type="checkbox"/> Heart disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol <input type="checkbox"/> Diabetes <input type="checkbox"/> Blood clots/phlebitis	<p style="text-align: center;">Clinician's Notes</p>
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Reproductive Health History

<input type="checkbox"/> Abnormal vaginal discharge/odor <input type="checkbox"/> Pain/bleeding during or after sex <input type="checkbox"/> History of abnormal Pap smear <input type="checkbox"/> Past/present history of GYN problems/surgery <input type="checkbox"/> Past/present history of breast problems/surgery Past/present history of a Sexually Transmissible Infection: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomonas <input type="checkbox"/> Herpes (oral of genital) <input type="checkbox"/> HPV (genital warts) <input type="checkbox"/> HIV/AIDS	<p style="text-align: center;">Clinician's Notes</p>
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Sexual History

<input type="checkbox"/> Never had sex <input type="checkbox"/> Had sex but not intercourse <input type="checkbox"/> Sexually active at present <input type="checkbox"/> Currently having sex with more than one person <input type="checkbox"/> Partner currently having sex with others besides you # of sexual partners in your lifetime _____ Age at first intercourse _____ Ever forced to have sex _____ Sexual orientation <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay/lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Transgender <u>Ever</u> had sex with a bisexual/gay man _____ <u>Ever</u> had sex with a past or present IV drug user _____	<p style="text-align: center;">Clinician's Notes</p>
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(See Other Side)

Menstrual History

Date last period began _____ Was it normal? _____
 Age period started _____
 # of days between periods _____ # of days of flow _____
 Flow is: light _____ moderate _____ heavy _____
 Cramping? _____
 Do you take medication for cramps? _____
 What kind? _____
 History of irregular periods? _____

Clinician's Notes**Pregnancy History**

Have you ever been pregnant? Yes _____ No _____
 If yes, how many:
 Full term _____
 Premature _____
 Miscarriage _____
 Abortion _____
 Tubal pregnancy _____
 Living children _____
 Pregnancy complications _____

Clinician's Notes**Personal History**

- Smoke cigarettes/cigars
- Drink alcohol (beer, wine, hard liquor)
 - Daily
 - Weekly
 - Monthly
 - Less than monthly
- Ever used street/designer/recreational drugs
 What type? _____
- Caffeine
- Exercise

Clinician's Notes**Birth Control History**

- Never used birth control
- Birth control methods used now or in past:
 - Condoms
 - Birth control pills
 - Depo Provera (shot)
 - IUD
 - Withdrawal method
 - Spermicides
 - Diaphragm/cervical cap
 - Rhythm/Natural Family Planning
 - Tubal ligation
 - Vasectomy
 - Norplant

Clinician's Notes