Name: ____ | SID: ____ | Age: _______

Women's Health History Form
Iowa State University
Thielen Student Health Center

The information used on this form is confidential. We ask these questions so that we can provide you with comprehensive care and counseling.

What brings you in today? ____

1. Menstrual History

When was the FIRST day of your last period? ________________
Was it normal? Y / N Age you started periods _______How often do you get periods? __________________
Any problems with your periods now? ____

2. Gynecology History

When was your last Pap smear? ___________________________
Have you ever had an abnormal Pap? Y / N What follow-up was done? _____________________________
Have you ever had any of the following? Please **check if applicable**.

Ovarian cyst		Sexual concerns	
Breast problems or surgery		Painful intercourse	
Gynecological surgery		Eating disorder/Weight concerns	
Frequent vaginal infection		Migraine headaches	
Frequent bladder infection		Blood clot (deep vein thrombosis)	
Sexually transmitted disease		Genital warts	
Herpes		Have you received the HPV (Gardisil) vaccine?	

3. Sexual History

Are you in a sexual relationship now? Y / N For how long? ____________________________
If no, when were you last sexually involved? ___________ At what age did you start having intercourse? _____
How many sexual partner(s) have you had? ____________
Are your partners: Male__________ Female __________ Both ____________
Have you ever been a victim of physical or sexual abuse/assault? Y / N

4. Contraceptive Use

If applicable, what contraceptive methods do you currently use (please include condoms, withdrawal, Plan B)?
____
Describe any problems/concerns with method(s):____

5. Obstetrical History

Have you ever been pregnant? Y / N
If yes, please indicate number: Full-term births ___ Pre-term births ___ Miscarriage/Elective Abortion ___
Living children ___

6. Family Gynecological History

Please check if you have family members with: Breast cancer ____ Ovarian cancer ____ Polycystic Ovaries ____
Endometriosis ____