USFSP
STUDENT AFFAIRS

# WELLNESS CENTER
# GYN HISTORY
***(Information is confidential)***

**PLEASE COMPLETE BOTH SIDES OF FORM**

Today's Date: _____ First day of last normal period: _____

At what age did your periods start? _____ Are your periods regular? Yes No

On the average, how many days do you usually flow? _____ Is the flow (circle): Light Moderate Heavy

Date of last Pap Smear: _____ Place/Facility: _____

Any Abnormal Pap Smears? No Yes If yes, date: _____ Place/Facility: _____

Ever had a Mammogram? No Yes If yes, date: _____ Any abnormal results? No Yes If yes, date: _____

Breast Implants? No Yes If yes, date: _____ Any problems? No Yes If yes, explain: _____

Sexually Active? No Yes If yes, circle as applicable: Oral Vaginal Anal

Date of last sexual contact: _____ Was this contact protected? Yes No

Partner(s): ____Male ____Female # of partners past 3 mos.: _____ # of lifetime partners: _____ Age first sexual intercourse: _____

Current method of contraception: _____ Use of condoms (circle): Always Occasionally Never

Are you concerned you may be pregnant? No Yes Number of Pregnancies:____ Deliveries:_____ Abortions:_____ Miscarriages: _____

Gynecological surgery? No Yes If yes, list: _____

***Methods of Contraceptives you have used in the past (circle):***

| | | | **Problems Experienced:** |
|---|---|---|---|
| Cervical Cap | Condoms | Depo Provera | |
| Diaphragm | IUD | Norplant | _____ |
| Oral Contraceptives (BCP) | Ortho Evra Patch | Nuva Ring | _____ |
| Spermicide | Sponge | Rhythm/Fertility Method | _____ |
| Withdrawal | Other: _____ | | _____ |
| | **None of the above** | | |

***Past/Current GYN Conditions (circle as applicable):***

| | | | **Problems Experienced:** |
|---|---|---|---|
| Bacterial Vaginosis (Gardnerella) | Genital Warts (HPV) | Pelvic Inflammatory Disease (PID) | |
| Bleeding Between Periods | Gonorrhea | Severe Menstrual Cramps | _____ |
| Breast Problems | Herpes (HSV) | Syphilis | _____ |
| Chlamydia | Nonspecific Vaginitis | Trichomonas | _____ |
| DES Exposure | Ovarian Disease | Yeast | _____ |
| | **None of the above** | | |

***OVER*** ***PLEASE CONTINUE ON REVERSE SIDE*** ***OVER***

**GENERAL MEDICAL HISTORY (circle as applicable):**

Anemia (Iron-deficiency) Depression Headaches (Migraine/Recurrent/Tension)

Blood clot in legs/lungs Eating Disorders High Blood Pressure

Urinary Tract Infections (Frequent) **None**

**FAMILY HISTORY - Indicate relationship of family member with condition(s) as applicable:**

Breast Cancer: _____ Ovarian Cancer: _____

Cervical Cancer: _____ Thyroid disorder:_____

Heart Attack/Angina/Stroke prior to age 50: _____ Uterus removed (hysterectomy):_____

Other Conditions: _____

**LIFESTYLE HISTORY:**

Alcohol Use? No Yes If yes, average intake (circle applicable): Daily Weekly Amount: _____

Is your use of alcohol a concern for yourself or others? No Yes If yes, previous treatment/therapy? No Yes

Balanced Diet? Yes No If no, how would you rate your diet (circle): Good Fair Poor

Do you consume four (4) servings of dairy/soy products daily or take calcium supplements? Yes No

Stable Weight? Yes No If no, are you satisfied with your weight? Yes No

Drug use? No Yes If yes, substance: _____ Frequency (check): ____ daily ____ weekly

Have you used needles to inject drugs? No Yes Tobacco Use? No Yes If yes, amount: _____

Regular Exercise? Yes No If yes, type of exercise: _____ Frequency: _____

History of any type of abuse? No Yes If yes, explain: _____ Currently in an abusive situation? No Yes

Other History: _____

**List medications you are currently taking on a regular basis (include birth control pills): _____**

**_____**

Have you received the HPV Vaccine? No Yes If yes, date: _____ Are you interested in receiving it? Yes No

Have you had any new medical problems or changes in medications since your last visit? No Yes

If yes, explain: _____

Please note here anything in particular you want to discuss with the Practitioner: _____

_____

_____

**Date of Birth: _____ Age:_____Current Telephone Number (include area code): _____**

**PRINT NAME: _____STUDENT I.D. #_____**

***Thank you very much!***