

Name: _____

UFID: _____

Age: _____

Local Address: _____ Phone: _____

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

WHAT BRINGS YOU IN TODAY?

1. MENSTRUAL HISTORY:

When was the **FIRST** day of your last period? _____

Was it normal? _____ Age of onset of periods _____ How often do you get your period? _____

Any problems with your periods now? _____ In the past? _____

2. GYNECOLOGY HISTORY:

When was your last Pap smear? _____

Have you ever had an abnormal Pap? _____ When? _____ What follow up was done? _____

Have you ever had any of the following?

- | | | | |
|---------------------------------|-------|---|-------|
| 1. Ovarian cyst | _____ | 7. Sexual concerns | _____ |
| 2. Breast problems or surgery | _____ | 8. Painful intercourse | _____ |
| 3. Gynecological surgery | _____ | 9. Eating disorder | _____ |
| 4. Frequent vaginal infection | _____ | 10. Preoccupation with weight or body image | _____ |
| 5. Frequent bladder infections | _____ | 11. Restriction of food intake, binging/purging | _____ |
| 6. Sexually transmitted disease | _____ | | |
| Genital warts/condyloma | _____ | | |
| Herpes | _____ | | |

If you have had a mammogram or ultrasound, indicate the date(s) and findings:

3. SEXUAL HISTORY:

Sexual Orientation:

____ Heterosexual ____ Bisexual ____ Lesbian/Gay ____ Transgendered ____ Prefer not to state

Are you in a sexual relationship now? _____ For how long? _____

If no, when were you last sexually involved? _____

If applicable, what contraceptive method do you or your partner use? _____

Is this a satisfactory method for you? _____

Have you ever been a victim of a physical or sexual assault? _____

Have you been in a relationship which involved hitting, slapping, kicking or other physical abuse? ____

Has anyone forced you to have sexual activities? _____

4. CONTRACEPTIVE HISTORY:

If applicable, what methods have you used. Describe any problems.

Hormonal Contraception:

Birth Control Pills	_____
Patch	_____
Vaginal Ring	_____
Depo Provera Injection	_____
Norplant	_____

Male/Female Condoms	_____
Diaphragm/Cervical Cap	_____
Spermicides	_____
Rhythm/Natural Family Planning	_____
Withdrawal	_____
IUD	_____
Tubal Ligation	_____

5. OBSTETRICAL HISTORY:

If you have ever been pregnant indicate:

Full term births _____ Preterm births _____ Spont. Miscarriage/Elective abortion _____ Living children _____

6. FAMILY HISTORY:

Do you have immediate family members with:

Breast cancer? _____ Ovarian cancer? _____

Signature _____

Date _____