Name:____ **Womens Health History Form**
University of Florida/SHCC

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?

#	Condition	
1.	Ovarian cyst	
2.	Breast problems or surgery	
3.	Gynecological surgery	
4.	Frequent vaginal infection	
5.	Frequent bladder infections	
6.	Sexually transmitted disease	
	Genital warts/condyloma	
	Herpes	

#	Condition	
7.	Sexual concerns	
8.	Painful intercourse	
9.	Eating disorder	
10.	Preoccupation with weight or body image	
11.	Restriction of food intake, binging/purging	

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

____

3. SEXUAL HISTORY:

Sexual Orientation/ Gender Identity:

____ 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:

Method	
Birth Control Pills	
Patch	
Vaginal Ring	

Method	
Male/Female Condoms	
Withdrawal	
IUD	
Norplant/Implanon	
Depo Provera Injection	

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? _______ High Blood Pressure? ______

Heart Disease? _______ Blood Clots? _______ Diabetes? ______ Other?______________

7. MEDICAL HISTORY:

Tobacco use: Type and Amount:______________________________________

List all other prescription medication you are taking______________________________

____

What surgeries have you had? ______________________________________

____

Do you have any past or present health problems that require a doctors care? ______________

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