### A. MENSTRUAL HISTORY

Age of first period ______________

Periods usually come every ________ days.

Periods usually last for ________ ___ days.

Was the last menstrual period normal in length and flow:
- Yes
- No

Do you have cramps with your period?
- Yes
- No

Do you take any medication for menstrual pain?
- Yes
- No

If yes, what ________

Does your pain interfere with work or class?
- Yes
- No

Number of pads / tampons used on heaviest day: ___________

Do you have bleeding between your periods?
- Yes
- No

### B. CONTRACEPTIVE HISTORY

- Not applicable (move to next section)

Have you used any of the following? (Check all that apply)
- Abstinence
- Condoms 100%
- Diaphragm
- Pills
- Shot
- Implant
- Ring
- Patch
- Skyla
- Mirena
- ParaGard
- Spermicide
- Emergency contraception
- Other ________________

What is your current method of birth control? ________________

Have you had sex without using any birth control method since your last menstrual period?
- Yes – date ____________
- No

### C. SEXUAL HISTORY

Have you engaged in sexual contact (oral, vaginal, anal) with:
- Men
- Women
- Both
- Neither

At what age did you become sexually active? ______________

How many partners in the last 12 months? ______________

Do you have a current sexual partner?
- Yes
- No

How long have you been with your current sexual partner? ______________

Have you ever been diagnosed with or treated for any of the following sexually transmitted diseases? (Check all that apply)
- None
- Chlamydia
- Genital herpes
- Oral herpes
- Genital warts
- Hepatitis
- Syphilis
- Gonorrhea
- Other ________________

How do you protect yourself against STDs? (Check all that apply)
- Abstinence
- Oral barriers
- Condoms
- Long-term monogamy
- STD testing for self
- STD testing of contact/partner
- Other ________________

Have you ever experienced any unwanted sexual contact as a child or an adult?
- Yes
- No

Have you ever had concerns about physical or emotional violence in a relationship?
- Yes
- No

### D. GYNECOLOGIC RELATED HISTORY

Have you ever had a pelvic exam?
- Yes
- No

Have you completed the HPV vaccine series (Gardasil)?
- Yes
- No

Have you ever had any of the following?
- Breast abnormalities
- Abnormal amount of hair growth (facial, chest, abdomen)
- Endometriosis
- Ovarian cysts
- Fibroids
- Pelvic Inflammatory Disease
- Abnormal Pap Smear ________________

### E. PREGNANCY HISTORY

Have you ever been pregnant?
- Yes
- No

If yes, what was the outcome?
- Birth
- Termination
- Miscarriage
- Tubal pregnancy

Complications/comments ________________
F. PATIENT MEDICAL HISTORY

Have you ever been diagnosed with or treated for any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Anemia</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Asthma</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Diabetes</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Cancer</td>
<td>☐</td>
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</tr>
<tr>
<td>High Cholesterol</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Thyroid Disorder</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Seizure/Epilepsy</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Additional conditions:
- Depression
- Severe Headaches
- Heart Abnormalities
- Mono in the last 6 months
- Liver Disease/Hepatitis
- Kidney Disease
- Urinary Tract Infections
- Blood Clots in legs, lung, brain
- #_____in past year
- Inflammation of leg veins
- Other

List past surgeries/hospitalizations:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

G. FAMILY HISTORY

Were you adopted? ☐ Yes ☐ No

Indicate below any family member (parents, grandparents, siblings, children) with any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Blood Clots</td>
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<tr>
<td>Elevated Cholesterol</td>
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</tr>
<tr>
<td>Diabetes</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Ovarian Cancer</td>
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<td>☐</td>
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<tr>
<td>Uterine Cancer</td>
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<td>☐</td>
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<tr>
<td>Colon Cancer</td>
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<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Family member / age diagnosed:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

H. HEALTH HABITS / WELLNESS HISTORY

Do you use tobacco products? ☐ Yes ☐ No If yes, how many per day?_________

Do you sometimes drink beer, wine or other alcoholic beverages? ☐ Yes ☐ No

If yes, how many times in the past year have you had 4 or more drinks in a day?________

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?________

Do you text while driving? ☐ Yes ☐ No

Do you wear a helmet when riding a bike or motorcycle and/or while rollerblading or skateboarding? ☐ Yes ☐ No ☐ N/A

Do you exercise routinely? ☐ Yes ☐ No If yes, how often?________

What is your selected food pattern? ☐ All food groups ☐ Vegetarian ☐ Lacto-ovo-vegetarian ☐ Vegan ☐ Other________

Patient Signature_________________________ Date_________________________

Clinician Comments:________________________________________________________

Clinician Signature________________________________________________________ Date_________________________

5/23/17:bah