Columbus State University Student Health Center – GYN HISTORY

Name: _____ Date: _____

ID#: _____ DOB: _____ First Day of Last Period: _____

Age Your Periods Began: _____ Menstrual Cycle: Regular: ☐ Irregular: ☐ Duration of Period: _____

Pain with Period: Rate 1-5 (with 5 being worst): _____

History of Migraines Headaches: Yes: ☐ No: ☐ History of Blood Clots: Yes: ☐ No: ☐

History of High Blood Pressure: Yes: ☐ No: ☐ Family History of Female Cancers: Yes: ☐ No: ☐

Sexually Active? Yes: ☐ No: ☐

Do You Use Protection to Prevent STI's (condoms, etc.)? Yes: ☐ No: ☐ Sometimes: ☐

Do You Experience Pain With Sex? Yes: ☐ No: ☐ History of STDs? Yes: ☐ No: ☐

IF YES: Date of STD(S): _____

Name of STD(S): _____

Current Birth Control: Type: _____ Complications with BC: YES ☐ NO ☐

History of Problems with a Previous BC? YES: ☐ NO: ☐ Name: _____

Date of last PAP: _____ Results: Normal: ☐ Abnormal: ☐

Where? _____

Received HPV Immunizations: Yes ☐ No ☐ # Received Pelvic Pain: Yes ☐ No ☐

Previous Gyn Surgeries: Yes ☐ No ☐ History of Cysts/Fibroids? Yes ☐ No ☐

Have You Ever Been Pregnant? YES: ☐ NO: ☐ # of Pregnancies: _____ Number of Live Births: _____

History of Pregnancy Complications? Yes: ☐ No: ☐

Other Concerns: