Columbus State University Student Health Center-GYN History

Name_____ **Date**:_____

909 _____ **AGE**: _____

First Day of your last period: _____

Age your period began: _____ Periods are: Regular_____ Irregular_____ How many days do they last? _____

Painful periods: Rate 0-5 (with 5 being worst) _____ Have you ever been sexually active? Yes ☐ No ☐

Your sex partners are: Men ☐ Women ☐ Both ☐

Number of sex partners: **in the last month**: _____ **in the last 6 months**: _____

When was your last sexual encounter? _____ Last encounter was with: Male ☐ Female ☐

What type of sex have you had: Vaginal ☐ Oral ☐ Anal ☐

Do you use condoms or other protection when having sex? Never ☐ Sometimes ☐ Always ☐

Have you taken Plan B? Yes ☐ No ☐ **Date**: _____ Have you ever been pregnant? Yes ☐ No ☐

Number of pregnancies: ____ Number of live births: ____ Complications with pregnancies? Yes ☐ No ☐

Current form of Birth Control: _____ Problems with this Birth Control? Yes ☐ No ☐

History of problems with a previous Birth Control? Yes ☐ No ☐ _____

Are you interested in starting birth control through the Student Health Center? Yes ☐ No ☐

Are you currently having pelvic pain? Yes ☐ No ☐

Date of last PAP (usually not done until age 21 yrs.): _____ **Results**: Normal Abnormal

Where was it done? _____

Do **You** have a **History** of**:** Migraine Headaches: Yes ☐ No ☐ High Blood Pressure: Yes ☐ No ☐

Blood Clots in your body: Yes ☐ No ☐ Sexual or Physical Abuse: Yes ☐ No ☐ GYN surgeries: Yes ☐ No ☐

Receiving HPV vaccines: Yes ☐ No ☐

Have **you** ever had: Yeast Infection ☐ Bacterial Vaginitis ☐ Pelvic Inflammatory Disease ☐ None of these ☐

Have **you ever had** a Sexually Transmitted Infection? Yes ☐ No ☐ **Date/s** of Infection: _____

Name of infection/s: _____

If you are you experiencing symptoms **now,** what are they? _____

Have any of **your partners** ever had a Sexually Transmitted Infection? Yes ☐ No ☐ Unsure ☐

If yes, name of infection: _____

Would you be interested in a free HIV test? Yes ☐ No ☐

Family History of Female Cancers? Yes ☐ No ☐