### 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 ever had an abnormal Pap smear:
- [ ] 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

### E. PREGNANCY HISTORY

Have you ever been pregnant:
- [ ] Yes
- [ ] No

If yes, what was the outcome:
- [ ] Birth #______date_________________
- [ ] Termination #______date_________________
- [ ] Miscarriage #______date_________________
- [ ] Tubal pregnancy #______date_________________

Complications/comments__________________________________________

Clinician Comments:__________________________________________

*200*
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>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
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<td></td>
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<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Disorder</td>
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<td></td>
</tr>
<tr>
<td>Seizure/Epilepsy</td>
<td></td>
<td></td>
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<tr>
<td>Blood Clots in legs, lung, brain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inflammation of leg veins</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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>
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<tr>
<td>Heart Attack</td>
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<tr>
<td>Blood Clots</td>
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<tr>
<td>Elevated Cholesterol</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Breast Cancer</td>
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<tr>
<td>Ovarian Cancer</td>
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<tr>
<td>Uterine Cancer</td>
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<tr>
<td>Colon Cancer</td>
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<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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________________

4/6/16:bah