

Name: \_\_\_\_\_

UIN: \_\_\_\_\_

Date: \_\_\_\_\_

## Women's Health Patient Questionnaire

### MENSTRUAL HISTORY

Are your periods usually regular (every 24-38 days)?

☐ Yes ☐ No ☐ NA \_\_\_\_\_

### Sexual Health History

What is your gender identity? \_\_\_\_\_

Gender assigned at birth? ☐ Female ☐ Male

Have you ever engaged in sexual contact (oral, vaginal, anal):

☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No

Partner(s)is/are

☐ Male ☐ Female ☐ Other \_\_\_\_\_

Have you ever been diagnosed with or treated for any of the following sexually transmitted infections? *(Check all that apply)*

☐ chlamydia ☐ gonorrhea ☐ genital herpes ☐ oral herpes

☐ genital warts/HPV ☐ hepatitis B/C ☐ syphilis ☐ HIV

☐ None

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

### GYNECOLOGIC RELATED HISTORY

History of breast, ovarian or uterine abnormalities?

☐ Yes ☐ No

Have you completed the HPV (Gardasil/Cervarix) vaccine series?

☐ Yes ☐ No ☐ Unsure

Have you ever had an abnormal pap or HPV?

☐ Yes ☐ No ☐ Never had a Pap Test

Have you had gynecological surgeries/hospitalizations?

☐ Yes ☐ No

### FAMILY HISTORY

Were you adopted? ☐ Yes ☐ No

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

**Family Member and Age Diagnosed:**

☐ Stroke \_\_\_\_\_ ☐ Heart Attack \_\_\_\_\_

☐ Blood Clots/Bleeding Disorders \_\_\_\_\_

☐ Diabetes \_\_\_\_\_ ☐ Breast Cancer \_\_\_\_\_

☐ Ovarian Cancer \_\_\_\_\_ ☐ Uterine Cancer \_\_\_\_\_

☐ Colon Cancer \_\_\_\_\_

Other Please Specify: \_\_\_\_\_

### CONTRACEPTIVE HISTORY

☐ Not applicable *(move to next section)*

Which birth control method are you **currently** using?

*(Check all that apply)*

☐ None ☐ Abstinence ☐ Withdrawal

☐ Natural Family Planning/Track Cycles

☐ Condoms ☐ Spermicide ☐ Diaphragm ☐ Pills

☐ Shot ☐ Implant ☐ Ring ☐ Patch ☐ IUD \_\_\_\_\_

☐ Emergency contraception ☐ Sterilization

### PREGNANCY HISTORY

Have you ever been pregnant? ☐ No

☐ Yes Year(s): \_\_\_\_\_

### Patient Medical History

Have you ever had:

☐ Migraines

☐ Liver or Kidney Disease

☐ Severe Headaches

☐ Acne

☐ Eating Disorders

☐ Anxiety and/or Depression

☐ Anemia

☐ Seizure/Epilepsy

☐ PCOS

☐ Cancer

☐ Diabetes

☐ Ulcerative Colitis/Crohn's

☐ Thyroid Disorder

☐ Heart Problems

☐ High Blood Pressure/High Cholesterol

☐ Blood Clots or Bleeding Disorder

☐ Urinary Tract Infection(s) in the last year \_\_\_\_\_

☐ Other: \_\_\_\_\_

List past surgeries/hospitalizations:

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Clinician Comments: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_

Date \_\_\_\_\_