

University of North Carolina School of the Arts
Health History for Women

In order to establish a reproductive health care history in your medical record, we are asking you to complete the enclosed form. As with all your medical records, we will retain this form in strict confidence. No access to this document by outside parties will be granted without your specific written consent.

Name _____ Age _____ Today's Date _____

Reason for visit: _____

When was the first day of your last period? _____ Was it normal? Y N

Is there a possibility that you might be pregnant? Y N Unsure

What was the date of your last Pap smear? _____

Have you had unprotected intercourse? Y N Unsure

Have you ever had HIV testing? Y N Are you interested in HIV testing? Y N

How old were you when you had your first period? _____

What are the average # of days between the onset of each period? _____

Do you have bleeding between periods? Y N

Do you skip or miss periods? Y N

Do you get menstrual cramps? Y N

How would you describe your menstrual flow: Heavy Moderate Light

Have you ever had:

Vaginal infections Y N What kind? _____

Unusual discharge Y N

Herpes Y N

Genital warts (HPV) Y N

Chlamydia Y N

Gonorrhea Y N

Abnormal Pap smear Y N

Have you ever had sexual intercourse? Y N Age at first encounter _____

Sexual partners have been Male Female Both

Number of sexual partners in lifetime _____ Number of partners this past year _____

Have you ever been pregnant? Y N

Present method of birth control _____

Past methods of birth control _____

Do you use condoms? Always Most of the time Some of the time Never

Do you feel safe in your current relationship? Y N _____

Have you been pushed, hit or made to feel unsafe in any of your relationships? Y N

OVER PLEASE

