Please Complete Form in Blue or Black Ink Today's Date______________

LEHIGH UNIVERSITY HEALTH AND WELLNESS CENTER
GYNECOLOGIC HISTORY

Name: ______________________________ **Date of Birth:** ________**Current Age**________ **LIN#:** _________
Current Mailing Address: ____
Street **City/State** **Zip Code**
Please check your preference of notification: _____**Cell Phone:** ____________________ _____**Secure MSG:**______________________

Are you currently having a problem you would like to discuss at today's visit? Yes _____No _____
If yes, please specify:

MEDICAL HISTORY

Have you ever been diagnosed with?
Yes ______No _____ Diabetes
Yes _____ No _____ High blood pressure
Yes _____ No _____ Blood clots
Yes _____ No _____ Heart disease
Yes _____ No _____ Migraine headaches

Do you currently?
Yes ______No _____ Smoke Cigarettes (How many/day?) ________________
Yes ______No _____ Consumed 4 or more drinks (one drink = 12 oz. beer, 8 oz. malt liquor, 5 oz. wine, or 1.5 oz. or a "shot" of hard alcohol) on a single occasion during the past two weeks?
Yes ______No _____ Take any medications? (List)______________________
____
Yes ______No _____ Have any allergies to medications?
(List)____

FAMILY HISTORY

Does anyone in your immediate family have any of the following?
Yes______ No _____ Heart disease (Who) ______________________________
Yes______ No _____ High blood pressure (Who) ______________________________
Yes______ No______ Stroke (Who) ______________________________
Yes _____ No______ Blood clot (Who) ______________________________
Yes______ No______ High Cholesterol (Who)______________________________
Yes _____ No _____ Cancer (What type/Who) ______________________________

GYNECOLOGIC HISTORY

First day of your last period__________________
Age period began __________________________
Number of days of menstrual flow____________
Yes _____ No______ Are your periods regular?
Yes______ No______ Do you examine your breasts?
Yes______ No______ Have you ever had a breast lump?
Yes______ No______ Have you ever had a pelvic exam?
Yes______ No______ Have you ever had a Pap smear? Date____
Yes______ No______ Have you ever had an abnormal pap smear? If yes result/when? ______

Yes _____No______ Have you ever been diagnosed with PCOS?
Yes _____No _____ Have you had the Gardisil vaccine?
#1_____ #2_____ #3_____
Yes _____No_____ Do you have significant cramps or pain with your periods?
Yes _____No_____ Do you take any medication for cramps?
(List) ______________________
Yes _____No _____ Do you have any bleeding or spotting between periods?
Yes _____No _____ Do you have any unusual vaginal discharge, itching, burning, or odor?

SEXUAL HISTORY

Age at first vaginal intercourse __________
Yes _____No _____ Have you ever been in a relationship where you have been threatened or harmed in any way?
Is/Are your partner(s) Male _____ Female _____ Both _____
Yes _____No _____ Are you currently (within the past 3 months) sexually active?
What type of sexual contact have you had (ever)? Oral _____ Vaginal _____ Anal _____
Yes _____No _____ Have you ever been pregnant?
Yes _____No _____ Do you think you might currently be pregnant?
Yes _____No _____ Have you had a new partner since your last gynecological exam?
What methods of contraception are you are currently using? ______________________________
Do you use condoms? Always _____ Sometimes _____ Never _____
Do you use condoms or dental dams during oral sex? Always _____ Sometimes _____ Never _____
Yes _____No _____ Have you ever been told you've had a sexually transmitted infection?
If so, which one(s) and when? Treated with? ________________________________
Yes _____No _____ Would you like to be tested for *Gonorrhea* and *Chlamydia*?
Yes _____No _____ Are you considering a new method of birth control? (Which)?________________________________

The American College of Obstetricians and Gynecologists recommends women have their first Pap smear at age 21 and continue every 3 years through age 29. For women 30 and older, less frequent screening may be done if HPV test done. The CDC recommends annual chlamydia testing for sexually active females 25 years old and younger.

Above information reviewed by: __________________________________MD / DO / CRNP Date:__________________________