UCI STUDENT HEALTH CENTER
HEALTH HISTORY FOR WOMEN

Name: __________________________ Age: ______ Student ID#: _______________ Appointment Date: _________________

Please read the statement on page 2 of this form and consult your health care provider if you have questions about this form or other concerns about your health.

Reason for visit: ____

Is this your first gynecological examination? ❑ Yes ❑ No

GYNECOLOGICAL

_____________ Age at onset of 1st period
_____________ 1st day of last normal period
_____________ Avg # days of menstrual flow
_____________ Avg # tampons/pads used daily
_____________ Avg # days between onset of each period
_____________ Any bleeding between periods?

❑ Yes ❑ No Any skipped or missed periods?
❑ Yes ❑ No Do you get cramps? If yes, how do you ______________________________________treat them?
❑ Yes ❑ No Have your periods changed in the last year?
_____________________________ If yes, in what way?

❑ Yes ❑ No Have you ever been pregnant?

If yes: # of pregnancies: ______________
# of children: _______________
# of abortions, miscarriages: _______________

Problems with any of the above: ____________________
____

Have you ever had or been exposed to:

Yes	No	Now	
❑	❑	❑	Vaginal infections
❑	❑	❑	Unusual discharge
❑	❑	❑	Herpes
❑	❑	❑	Warts
❑	❑	❑	Chlamydia
❑	❑	❑	Gonorrhea
❑	❑	❑	HIV (AIDS Virus)
❑	❑	❑	An abnormal pap smear
❑	❑	❑	A problem requiring a visit to a gynecologist? Describe: ___________

____

❑ Yes ❑ No If age 26 or younger, are you interested in receiving Gardasil (HPV vaccine)?

SEXUAL HISTORY

❑ Yes ❑ No Have you ever been sexually involved with another person?

If yes, age at first encounter_________
If yes, partners are or have been: ❑ Male ❑ Female ❑ Both
If yes, # of partners _______________
Do you have questions or wish to discuss sexual orientation, sexual expression, masturbation, rape, incest, sexual abuse, other issues of sexuality? ❑ Yes ❑ No

CONTRACEPTIVE HISTORY

Present method of contraception:
____

Past Methods	Date	Problems
___________	___________	______________________
___________	___________	______________________

Do you use condoms to prevent sexually transmitted diseases?
❑ Yes ❑ No

YOUR PAST MEDICAL HISTORY

Yes	No	Now	Have You Ever Had?
❑	❑	❑	High blood pressure
❑	❑	❑	Epilepsy
❑	❑	❑	Migraine headaches
❑	❑	❑	Varicose veins
❑	❑	❑	Hepatitis or other liver disease
❑	❑	❑	Diabetes
❑	❑	❑	Blood clots
❑	❑	❑	Heart murmur
❑	❑	❑	Breast lumps
❑	❑	❑	Thyroid disorders
❑	❑	❑	Asthma
❑	❑	❑	Painful or frequent urination
❑	❑	❑	Bladder or kidney infections
❑	❑	❑	Depression or mood swings
❑	❑	❑	Weight gain or loss of 10 lbs. or more within the past year.

Do you use any of the following? How many?

			Per day / Per Week
❑ Yes	❑ No	Cigarettes	_______ / ________
❑ Yes	❑ No	Alcohol	_______ / ________
❑ Yes	❑ No	Recreational Drugs	_______ / ________
❑ Yes	❑ No	IV Drugs	_______ / ________

HOSPITALIZATION – SURGERY

Date	Diagnosis/Treatment
___________	___________________________________
___________	___________________________________
___________	___________________________________

Have you received blood or blood products between 1977-85?
❑ Yes ❑ No

YOUR FAMILY HISTORY

Yes	No	Don't Know	Has any close relative had?
❑	❑	❑	Heart attack before age 50
❑	❑	❑	Breast cancer
❑	❑	❑	Uterine, cervical or ovarian cancer
❑	❑	❑	Stroke
❑	❑	❑	Diabetes
❑	❑	❑	Migraine headaches
❑	❑	❑	High blood pressure
❑	❑	❑	Thyroid disorder
❑	❑	❑	Clotting disorder

SELF CARE

Do you take daily medication or vitamins?
❑ Yes, Specify: _________________________ ❑ No

❑ Yes ❑ No Do you have questions or concerns specific to lesbian health?

❑ Yes ❑ No Do you have questions or concerns specific to domestic violence?

Any other questions? _________________________________

FOR STAFF USE ONLY	Clinical Review	Init	Date	Clinical Review	Init	Date
	____________	_____	_____	____________	_____	_____
	____________	_____	_____	____________	_____	_____

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

For many issues related to women's health care, we have prepared information pamphlets and designed programs to aid you in learning about your body and yourself. Please feel free to ask us about any of these subjects.

Below are some commonly asked questions about this form:

I'm uncomfortable with some of the questions. Do I have to answer all of them?

No. If you are uncomfortable with a question and feel reluctant to answer it, you may leave it blank and discuss it with your practitioner.

Why do you need to know how many tampons I use each day?

This question is designed to help the practitioner assess the amount of menstrual flow. Excessive blood flow could indicated a problem such as anemia.

Why is it necessary to know the age at which I first had sex?

Age at first intercourse can indicate that a woman is at greater risk for infections and sexually transmitted diseases (and other gynecological problems). Additionally, some young women may have experienced unwanted sexual advances earlier in their lives and they may wish to discuss them at this time.

I'm uncomfortable with the question about masturbation, incest, rape, and other issues. What is this all about?

Our intension in asking this question is to provide an opportunity to discuss any one of these sensitive issues with a medical professional. These issues can directly affect your present and future sexual expression and relationships.