

STUDENT HEALTH SERVICES MEDICAL HISTORY

NAME: _____ ID: _____ DOB: _____ DATE: _____

ADDRESS: _____ UNG BOX # _____

CITY, STATE, ZIP _____

How would you like to be contacted for results of tests sent out to the reference lab? (please circle)

Home address or Box number or Phone number

Please answer the following questions regarding your periods:

- 52) How many days do your periods last? _____
53) Do you have periods every 24-35 days? _____
54) Do you have bleeding between periods? _____
55) How old were you when your periods began? _____
56) Do you have cramps requiring medication? _____
57) How many tampons/pads do you use on your heaviest days? _____

Please answer the following questions. They will help us determine your risk of having a sexually transmitted infection.

- 58) At what age did you first have sexual intercourse? _____
59) Are you currently having sexual intercourse? _____
60) Does your current partner have other partners? _____
61) How many partners have you had sexual intercourse with in the past year? _____
62) Are your sexual partners _____ men _____ women _____ both
63) Do you use condoms? _____ always _____ occasionally _____ never
64) Have you ever had _____ Chlamydia _____ Gonorrhea _____ Trichomonas _____ Syphilis _____ Genital Herpes
_____ Genital warts _____ Pelvic Inflammatory Disease (PID) _____ Other sexually transmitted infections
65) **Gonorrhea and Chlamydia testing are available for a small additional cost. Do you desire this testing?**
_____ Yes _____ No **Client Signature:** _____

Birth Control History:

- 66) Check if you have ever used: ___ Condoms ___ Pills ___ Spermicides ___ Sponges ___ Rhythm ___ Diaphragm
___ Cap ___ IUD ___ Norplant ___ Depo injections ___ Other _____
67) Describe any problems with past methods _____
68) What method(s) are you currently using? _____ How long _____ Problem? Yes No
69) What method(s) would you like today? _____

Pregnancy History:

- 70) Have you ever been pregnant? _____ *If no. sign and date form below.*
71) Have you ever had an infection after the birth of a child, abortion or miscarriage? _____
72) Number of living children _____

List your pregnancies in order below:

- Number of weeks pregnant _____
Date pregnancy ended _____
How pregnancy ended _____ abortion _____ miscarriage _____ live birth _____ tubal pregnancy _____ fetal death/still born
What type of delivery _____ vaginal _____ c-section
Pregnancy complications _____ toxemia _____ genetic abnormality _____ gestational diabetes

Number of weeks pregnant _____
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What type of delivery _____ vaginal _____ c-section
Pregnancy complications _____ toxemia _____ genetic abnormality _____ gestational diabetes

Client Signature _____ Staff Signature _____ Date _____