[Patient label goes here]

Patient's Name_____

Student ID#_____; Age _____

STUDENT HEALTH SERVICE
University of Iowa
4189 Westlawn
Iowa City, Iowa 52242

GYNECOLOGY HEALTH HISTORY FORM

Preferred Name if different from above: _____

Date: _____

Gender: ☐ Male ☐ Female ☐ Transgender: _____

☐ Single ☐ Married ☐ Divorced ☐ Partnered (with: ☐ same sex ☐ opposite sex ☐ other: _____)

☐ Undergraduate ☐ Graduate Major: _____ Graduation Date: _____

Reason for visit: ☐ Annual Exam ☐ Pap smear ☐ Discuss contraception ☐ Refill contraceptives ☐ STI testing

MEDICATIONS: _____

Past History:

Surgeries (type of surgery and dates): _____

Chronic medical problems/hospitalizations: _____

Migraine headaches ☐ Yes ☐ No Liver disease ☐ Yes ☐ No Blood Clots ☐ Yes ☐ No

Do you frequently feel depressed or anxious? ☐ Yes ☐ No Do you feel safe in your living environment? ☐ Yes ☐ No

Have you ever had your cholesterol checked? ☐ Yes ☐ No Are you happy with your weight? ☐ Yes ☐ No

Chickenpox? Had disease? ☐ Vaccination x2 ☐

Gynecological History:

Date of last Pap smear: _____ Date of last yearly exam (if different): _____

Have you ever had an abnormal pap? (date): _____ Have you had a colposcopy/LEEP? (date): _____

First day of last 2 menstrual periods: _____ & _____ How long does period last? _____

Usual number of days from start of one period to start of next: _____ Irregular bleeding? ☐ Yes ☐ No

Are you/have you ever been sexually active: ☐ Never been ☐ Not currently ☐ Currently sexually active

Do you have sex with men ☐ women ☐ both ☐ or other☐ _____

Have you had more than 5 lifetime sexual partners? ☐ Yes ☐ No

Have you had a change in partners in the past 3 months? ☐ Yes ☐ No

Current method of contraception/STI prevention: ☐Nothing ☐Condoms ☐Nuvaring ☐Depo ☐Implanon ☐IUD ☐Pill

Total number of pregnancies if any: ☐ None; # of children: _____; # of miscarriages: _____; # of terminations: _____

Social History:

Do you use/take/do the following? If yes how much and how often?

Tobacco: ☐ No ☐ Yes _____ Multi vitamin: ☐ No ☐ Yes _____

Alcohol: ☐ No ☐ Yes _____ Calcium/Vit D: (3 serv/d) ☐ No ☐ Yes _____

Recreational Drugs: ☐ No ☐ Yes _____ Seatbelts: ☐ No ☐ Yes _____

Exercise: (Type, frequency) ☐ No ☐ Yes _____ Sunscreen: ☐ No ☐ Yes

☐ Adopted

Biological Family History: Has a family member had the following?		Bleeding Prob/Clotting	Cancer	Depression/ Anxiety	Diabetes	Heart Disease	High Cholesterol	High Blood Pressure	Stroke	Substance Abuse	Thyroid	Other
Mother												
Father												
MGM												
MGF												
PGM												
PGF												
Other												

MGM=Maternal Grandmother; MGF=Maternal Grandfather; PGM=Paternal Grandmother; PGF=Paternal Grandfather