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

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Client Signature _____Staff Signature _____ Date _____