

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: _____ Email: _____

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 _____ 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 _____

Yes _____ No _____

Yes _____ No _____

Yes _____ No _____

Yes _____ No _____

Yes _____ No _____

Have you ever been diagnosed with PCOS?

Have you had the Gardasil vaccine?

#1 _____ #2 _____ #3 _____

Do you have significant cramps or pain with your periods?

Do you take any medication for cramps? (List) _____

Do you have any bleeding or spotting between periods?

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 2 years through age 29. For women 30 and older, once 3 consecutive Paps have been normal, screening may continue every three years. The CDC recommends annual chlamydia testing for sexually active females 25 years old and younger.

Above information reviewed by: _____ MD / DO / CRNP Date: _____