200

McKinley Health Center
Student Affairs/University of Illinois at Urbana-Champaign

HISTORY FORM
WOMEN'S HEALTH CLINIC

place label here

Name:

UIN:

Date:

PERSONAL HISTORY

- Age at onset of menstruation _____ Age at first intercourse_____
  Average time from FIRST DAY of one period to FIRST DAY of next period _____ days
  Usual length of menstrual period _____ days. Number of pads/tampons used on heaviest day____
- Do you have pain with your period? ☐ Yes ☐ No
  If YES, ☐ pain does not usually interfere with daily activity
  ☐ pain causes me to miss class or work
  ☐ pain causes me to go to bed
  Medication used_____Does it help? ☐ Yes ☐ No
- Have you had a pelvic exam or pap smear before? ☐ Yes ☐ No
- Are you currently in a sexual relationship? ☐ Yes ☐ No
- Are your past or present sexual partners: ☐ Male ☐ Female ☐ Both
- Have you ever been pregnant? ☐ Yes – what year(s)?_____ ☐ No
  If YES, total pregnancies _____; births _____; miscarriage _____;
  elective termination _____; ectopic pregnancy _____.
- Have you ever had a painful or frightening sexual experience? ☐ Yes ☐ No
- Do you have concerns about a past or current experience with physical or emotional violence in a dating or family relationship? ☐ Yes ☐ No

- Current method of birth control _____ Not Applicable ☐
  What methods of birth control have you used in the past?_____

- Does your diet provide a variety of milk products (or calcium supplement), vegetables/fruits, breads/cereals, and protein? ☐ Yes ☐ No
  Does concern about your weight or food interfere with your studies/work? ☐ Yes ☐ No
  Do you compensate for eating with purging or laxative use? ☐ Yes ☐ No
- How often do you exercise? _____ days per week _____minutes per day
  Do you smoke? ☐ Yes, _____ cigarettes /day, ☐ No
  Do you drink alcohol? ☐ Yes, _____ drinks / week, ☐ No
  Do you regularly use seatbelts? ☐ Yes ☐ No
  Do you regularly use bicycle/motorcycle helmet? ☐ Yes ☐ No ☐ NA

List medications taken regularly (including prescription meds, vitamins, herbal supplements, nutritional supplements, etc.) _____

Do YOU have a history of:

YES	NO	
☐	☐	Abnormal pelvic exam (ovarian cyst, uterine fibroids, uterine/vaginal abnormality)
☐	☐	Vaginal bleeding (other than your normal period)
☐	☐	Abnormal pap test - Date
☐	☐	Cryotherapy, laser or LEEP treatment of cervix - Date
☐	☐	Sexually transmitted disease (gonorrhea, chlamydia, herpes, genital warts, hepatitis B, HIV)
☐	☐	Pelvic inflammatory disease
☐	☐	Endometriosis
☐	☐	Breast abnormality
☐	☐	Abnormal amount of hair growth (facial, chest, abdomen)

(continued on back)

McKinley Health Center
Student Affairs/University of Illinois at Urbana-Champaign

place label here

Name:

UIN:

Date:

HISTORY FORM
WOMEN'S HEALTH CLINIC (page 2)

Personal Health History: Continued

YES	NO	
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Elevated cholesterol levels
☐	☐	Thyroid disorder
☐	☐	Diabetes
☐	☐	Seizure disorder/epilepsy
☐	☐	Severe headache/migraines
☐	☐	Cancer
☐	☐	Eating disorder
☐	☐	Depression
☐	☐	Blood transfusion
☐	☐	Bleeding disorder
☐	☐	Blood clots in leg, lung, brain, inflammation of leg veins
☐	☐	Heart abnormality (murmur, irregular rate/rhythm)
☐	☐	Elevated blood pressure
☐	☐	Liver disease/hepatitis or mono in past 6 months
☐	☐	Kidney disease
☐	☐	Urinary tract infection - _____ # in past year
☐	☐	Other significant illness/disease_____

List past surgery or hospitalization:_____

Family History

YES	NO		*List person(s) affected: only include grandparents, Parents, siblings and children):*
☐	☐	Stroke	_____
☐	☐	Heart attack	_____
☐	☐	Blood clots	_____
☐	☐	High blood pressure	_____
☐	☐	Diabetes	_____
☐	☐	Elevated cholesterol	_____
☐	☐	Thyroid disorder	_____
☐	☐	Substance /alcohol abuse	_____
☐	☐	Cancer (list type, family member, and age of onset)	_____
☐	☐	Other	_____

Patient's signature:_____ **Date:**_____

Reviewed by – Signature:_____ Date:_____

(reviewed 6/21/05) 11/16/06:bah