



Women's Health Clinic Medical History Form

Name: _____ Age: _____ DOB: _____ W# _____

Mailing Address: _____ Parish of Residence _____

City/State/Zip _____ Phone _____ Email _____

Preferred method of contact _____

Please check one of the following:

This is my routine annual PAP _____ This is my 6 month repeat PAP _____
This is my first PAP _____ I am not here for a PAP _____

Reason for visit: _____

At what age did you start menstruation? _____ 1st day of last menstrual period _____

Have you had or do you have any of the following:

- 1. Maternal DES exposure Yes _____ No _____
- 2. Have you had any STD? Yes _____ No _____
If yes: Herpes _____ Syphilis _____ Gonorrhea _____ HIV _____ Chlamydia _____ Warts/HPV _____ Chancroid _____
- 3. Previous pregnancy Yes _____ No _____
If yes: # of pregnancies _____ # of births _____ miscarriages _____ abortions _____
- 4. Abnormal PAP smear Yes _____ No _____
- 5. Abnormal breast exam Yes _____ No _____
- 6. History of cancer Yes _____ No _____

During the past year have you had any of the following?	Yes	No		Yes	No
Severe cramping	_____	_____	Frequent Headaches	_____	_____
Dizziness or fainting	_____	_____	Swelling or bloating	_____	_____
Increased Body Hair	_____	_____	Leg Cramps	_____	_____
Dilated leg veins	_____	_____	Irregular periods	_____	_____
Bleeding between periods	_____	_____	Prolonged periods	_____	_____
Breast Changes	_____	_____	Painful intercourse	_____	_____
Weight gain/loss (unplanned)	_____	_____			

If yes to any above, please explain _____

Are you sexually active? Yes _____ No _____ If yes what age started? _____ =

How many partners have you had (lifetime)? _____ Currently? _____ Male Partners _____ Female Partners _____

Are you concerned you may have an STD? Yes _____ No _____ Date of last HIV test _____

Condom usage: Always _____ Sometimes _____ With last sexual encounter _____

What form of birth control do you use? _____

Do you desire birth control? No _____ Yes _____ Type: _____

Do you check your moles each month? Yes _____ No _____ Do you check your breasts each month? Yes _____ No _____

Any questions or concerns? _____