



## Women's Health Clinic Medical History Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ W# \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Phone \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Date of Last PAP \_\_\_\_\_ Normal \_\_\_ Abnormal \_\_\_ Marital Status \_\_\_\_\_ Children \_\_\_\_\_

Reason for visit: \_\_\_ Routine/annual exam and PAP \_\_\_ 6 month follow up PAP \_\_\_ Other

Problem(s) List: \_\_\_\_\_

At what age did you start menstruation? \_\_\_\_\_ 1<sup>st</sup> day of last period \_\_\_\_\_

Have ***YOU*** had any of the following:

1. Maternal DES exposure Yes \_\_\_ No \_\_\_
2. Have you had any STD? None \_\_\_ Herpes \_\_\_ Syphilis \_\_\_ Gonorrhea \_\_\_ HIV \_\_\_ Chlamydia \_\_\_ Warts/HPV \_\_\_ Chancroid \_\_\_
3. Previous pregnancy Yes \_\_\_ No \_\_\_ # of pregnancies \_\_\_ # of births \_\_\_ # of other \_\_\_

During the past year have you had any of the following?	Yes	No		Yes	No
Nausea/Vomiting	___	___	Frequent Headaches	___	___
Dizziness or fainting	___	___	Increased Body Hair	___	___
Swelling or bloating	___	___	Dilated leg veins	___	___
Leg Cramps	___	___	Breast Changes	___	___
Weight gain or loss	___	___			
Painful intercourse	___	___			

If yes to any above, please explain \_\_\_\_\_

Do you have any of the following? Yes No

1. Severe Cramping \_\_\_
2. Bleeding between periods \_\_\_
3. Prolonged Periods \_\_\_
4. Irregular periods \_\_\_
5. Other \_\_\_\_\_

Are you sexually active? Yes \_\_\_ No \_\_\_ What age started? \_\_\_\_\_ More than one partner currently? Yes \_\_\_ No \_\_\_

How many partners have you had (lifetime)? \_\_\_\_\_ Male Partners \_\_\_ Female Partners \_\_\_

Are you concerned you may have an STD? Yes \_\_\_ No \_\_\_ Would you like testing? Yes \_\_\_ No \_\_\_ Date of last HIV test \_\_\_\_\_

Condom usage: Always \_\_\_ Sometimes \_\_\_ With last sexual encounter \_\_\_ Not sexually active \_\_\_

Are you using any form of birth control?(condoms, pill, etc.) No \_\_\_ Yes \_\_\_ Type \_\_\_\_\_

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? \_\_\_\_\_



## Women's/Men's Health Clinic

### Statement of Acknowledgement

Your examination may include a number of routine laboratory tests as well as a PAP smear. There is no fee to see the Nurse Practitioner, but ***there is a charge for lab tests/PAP smears.*** Please ask the nurse for the total cost. You will be notified if any of your tests are abnormal. PAP tests cost \$45.00, which includes a urine pregnancy test.

FEMALES: ***On occasion, your PAP will require a Physician Over-Read at the lab which will include an additional \$60.00 fee.*** You will be notified if this was required at the lab and you will have to pay the Student Health Center. Please sign to acknowledge that you are aware of this fee.

If you have a Take Charge card, you are responsible for ensuring that your card and benefits are current and up-to-date. If it is not, the lab will charge you for the tests run and you will be responsible for payment. We cannot bill Take Charge for the mandatory urine pregnancy test, so this \$5.00 will be your responsibility.

If you make an appointment with the Women's/Men's Health clinic and don't show up for an appointment and don't call to cancel the appointment, you may be charged a "no show" fee or be put on suspension from using the Women's/Men's Health Clinic. *I understand this is to ensure that everyone has a chance to get in to see the Practitioner.*

#### **NOTICE AND ACKNOWLEDGMENT OF WOMEN'S/MEN'S HEALTH CLINIC POLICIES:**

I acknowledge that I have read the above policies.

\_\_\_\_\_  
Signature & Student I.D. (W#)

\_\_\_\_\_  
Date