WOMEN'S HEALTH HISTORY FORM
SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
HEALTH SERVICE

_____ _____ _____
Last Name First Name Middle Initial

_____ _____
ID Number Date of Birth

Date of first day of last menstrual period _____
Was your last period normal? _____
Age of first menstrual period? _____
Length of menstrual flow _____ Interval between periods _____
When was your last pelvic exam? _____

Do you have any of the following?	Yes	No
Bloating before / during your period?		
Mood changes before your period?		
Breast tenderness?		
Excessive cramping during your period?		
Bleeding between your regular periods?		
Pain with sexual intercourse?		
Foul odor or abnormal vaginal discharge?		
Vaginal itching?		
Pain or burning with urination?		
Do you douche?		
Are you currently sexually active?		
Have you ever been sexually assaulted?		
Are you pregnant now?		
Are you planning a pregnancy soon?		

Birth Control Method

What method are you using now? Circle one:

abstinence
"pill" (name _____)
depo-provera "shot"
other (name _____)
condoms
condoms & spermacide
patch
vaginal ring

Are you having any problems with your current method? _____Yes _____ No
Are you interested in trying a different method? _____ Yes _____ No

Obstetric History

Enter number: Live births _____ Miscarriages or still births _____ Abortions _____
Total pregnancies _____
List month/year of deliveries or terminations beginning with the most recent _____
_____
Describe any complications of pregnancy, deliver, or abortion _____
_____

We will notify you if you have abnormal test results.

_____ _____
Telephone Number Date