

Central Michigan University
Health Services

CONFIDENTIAL WOMEN'S HEALTH HISTORY

This information is confidential and will not be released to anyone without your signed authorization.

Name: _____ Campus ID#: _____ Birthdate: _____

1. Have you ever had a pelvic exam?	Yes	No
2. On what date did your last period begin?		
3. How old were you when your periods started?		
4. How many days are there usually from the first day of your period to the first day of the next period?		
5. How many days do your period last?		
6. Are your periods usually: heavy medium light ?		
7. On your heaviest day, how many pads or tampons do you need?		
8. Did your last period start on time and was the flow normal?	Yes	No
9. Sexual orientation: heterosexual gay/lesbian bisexual		
10. Do you currently have a sexual partner? If yes, for how long? If no, how long since last sexual contact?	Yes	No
11. Have you ever had sex without a condom?	Yes	No
12. Age at first sexual intercourse?		
13. Estimate the total number of sexual partners you have had in your lifetime.		
14. Have you ever been tested for HIV/AIDS?	Yes	No
15. Do you think you may be pregnant now?	Yes	No
16. Have you ever been pregnant?	Yes	No
17. Did pregnancy end in: childbirth miscarriage abortion		
18. Do you use tampons?	Yes	No
19. Were you ever sexually abused as a child?	Yes	No
20. If yes, was it ever reported to anyone?	Yes	No
21. At what age did the incident (s) occur?		
22. Did you ever have a sexual encounter that was not with your consent? (i.e., rape, date rape, acquaintance rape)	Yes	No
23. If yes, was it ever reported to anyone?	Yes	No
24. At what age did the incident(s) occur?		
25. Did you ever receive counseling for sexual abuse/assault (rape, incest, etc.)?	Yes	No
26. Are you currently involved in a physically or emotionally abusive relationship?	Yes	No
27. Do you smoke?	Yes	No
28. If yes, how many packs a day and for how long?		
<i>Continued on the other side</i>		

29. Do you drink alcohol?								Yes	No
30. How many days a week do you drink?	1	2	3	4	5	6	7		
31. How many drinks per occasion?	1-2	3-5	6-9	10 or more					
32. Any other substance use? Please specify:									
33. Any special concerns regarding sexuality or other health problems? Please specify.									
34. Are you currently using a method of birth control?								Yes	No
35. Which method :								Past	Current
Abstinence									
Oral contraceptives (birth control pill)									
Natural family planning									
Withdrawal									
Emergency contraception (Morning After Pill)									
Condom									
Condom with spermicide									
Vaginal Sponge									
Spermicidal vaginal cream, foam, suppository									
Diaphragm									
IUD									
Norplant Implant									
Depo Provera Injections									
Tubal Ligation									
Partner had a vasectomy									
Abortion Pill (Mifeprex/RU 486)									
Surgical Abortion									
Other (specify)									
36. Please check any of the following that you are currently experiencing or have had in the past:								Past	Current
Vaginal odor/itching/burning									
Vaginal discharge									
Infection in uterus/tubes/ovaries (PID)									
Sexually transmitted disease (STD)									
Pain or bleeding with intercourse									
Severe premenstrual discomfort									
Unusual periods in the past year									
Abnormal Pap Smear									
Uterine growths, fibroids									
Cysts on ovaries									
Hospitalization/surgery for female problems									
Headaches or migraines									
Mental/emotional problems/depression									
Varicose veins or blood clots									
37. Please check any of the following that you or a member of your family has experienced. Please specify the sex of the person and indicate relationship.								Male	Female
Thyroid disease									
High blood pressure/stroke									
High blood fat levels (cholesterol)									
Gall bladder disease									
Diabetes									
Cancer of breast or female organs									
Heart attack before age 50									
Blood clots									
Other (specify)									

Signature: _____

Date: _____

Provider Review (Initials): _____

Date: _____