

29. Do you drink alcohol?		Yes	No
30. How many days a week do you drink? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/>			
31. How many drinks per occasion? 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-9 <input type="checkbox"/> 10 or more <input type="checkbox"/>			
32. Any other recreational drug use? Please specify:			
33. Have you received HPV vaccine (Gardasil)? 1 dose [<input type="checkbox"/>] 2 doses [<input type="checkbox"/>] 3 doses [<input type="checkbox"/>] When?		Yes	No
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			
Nuva Ring			
Spermicidal vaginal cream, foam, suppository			
Diaphragm			
IUD (e.g., Mirena)			
Ortho Evra skin patch			
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: _____