GANNETT HEALTH SERVICES
110 Ho Plaza , Ithaca, New York 14853-3101
(607) 255-5155 Fax 255-0269

FEMALE HEALTH HISTORY

Name ________________________

Date ____________ ID # ____________ DOB ____________

Phone ____________ PCP ____________ MRN ____________

All records are **CONFIDENTIAL**. Information is released only with your written permission or as required by law.

What is the main purpose of your visit? ❑ 1st Annual ❑ Annual ❑ Birth control options ❑ Other ____________
❑ Sexually transmitted infections (STI) screen

Please answer each question to help the clinician provide appropriate care for you.

PATIENT MEDICAL HISTORY:

Have you been diagnosed with or treated for any of the following:

	No	Yes
Diabetes	❑	❑
Cancer	❑	❑
Depression	❑	❑
Abdominal Surgery	❑	❑
Seizure, Convulsions	❑	❑
Hepatitis or Liver Disease	❑	❑
Urinary Tract Infections	❑	❑

	No	Yes
High Cholesterol	❑	❑
High Blood Pressure	❑	❑
Migraine Headache	❑	❑
Blood Clots	❑	❑
Kidney Disease	❑	❑
Tuberculosis	❑	❑
Gallbladder Disease	❑	❑
Heart Condition	❑	❑

Gynecological Conditions:	No	Yes	
Abnormal Pap	❑	❑	When? ____________
Colposcopy	❑	❑	When? ____________
Any Breast Problems	❑	❑	Identify ____________
Vaginal Infections	❑	❑	Type: ____________
Endometriosis	❑	❑	
Infertility	❑	❑	
Pelvic Inflammatory Dis.	❑	❑	
Ovarian Cysts	❑	❑	
Ovarian, Vaginal or Uterine Surgery	❑	❑	

Cervical Treatment:	No	Yes
Cryotherapy	❑	❑
LEEP	❑	❑
Laser	❑	❑
Polyp Removed	❑	❑

Immunizations completed:	No	Yes	Year
Rubella (German Measles)/titer	❑	❑	________
Hepatitis B (series of three)	❑	❑	________
Sickle Cell Test	❑	❑	________ Result ____________

List any **medications** you are taking now (including herbal): ________________________

List any **allergies** that you have: ________________________

Notes________________________

FAMILY HISTORY:

Were you adopted? ❑ No ❑ Yes

Please note the **ages** at which any of the following have been diagnosed:

	Father	Mother	Brother/ Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cancer / type							
Diabetes							
Heart Disease/Attack							
High Blood Pressure							
High Cholesterol							
Stroke							
Blood Clot Disorder							

Notes: ________________________

MENSTRUAL HISTORY

Age of first period ________
Periods come every ________ days
Periods usually last ________ days
First day of last period ________ Was it normal? ❑ No ❑ Yes
Have you ever had spotting between periods? ❑ No ❑ Yes
Periods are now: ❑ light ❑ moderate ❑ heavy
❑ regular ❑ irregular ❑ painful ❑ other ________
Do you take any medications for PMS or menstrual complaints?
❑ over the counter ❑ prescription ________

What do you use? ❑ tampons ❑ pads ❑ both

Notes:________________________

ANNUAL EXAM

Is this your first pelvic exam? ❑ No ❑ Yes

Any concerns? ________________________

Date of last pap ________ Result ________

How often do you do self-breast exams? ________

BSE demonstrated ❑

PLEASE CONTINUE ON BACK SIDE ↓

SEXUAL HISTORY

Have you engaged in sexual contact (oral, vaginal, anal) with:
❑ Men ❑ Women ❑ Both ❑ Neither
If yes, at what age did you become sexually active? ______________

How many sexual partners have you had? _______________________

If presently monogamous, how long? ___________________________

Have you ever been diagnosed with or treated for any of the following:

❑ Chlamydia ❑ Genital Herpes ❑ Oral Herpes ❑ HPV (genital warts)
❑ Hepatitis B ❑ Syphilis ❑ Gonorrhea ❑ Other ________________

Have you discussed STI risk with contacts/partners? ❑ No ❑ Yes

How will you protect yourself against STIs? (check all that apply)

❑ Abstinence
❑ Oral barriers
❑ Condom
❑ Long-term mutual monogamy
❑ STI testing - Self
❑ STI testing - Contact/Partner(s)
❑ Other ____________________

CONTRACEPTIVE HISTORY (If applicable)

❑ Not applicable

If applicable, have you have ever used any of the following:
(circle all that apply) Age of use

- Abstinence _____
- Barrier Method: condom, diaphragm, _____
- Hormonal: pills, shot, Norplant, ring, patch _____
- IUD _____
- Spermicide: foam, gel, film, suppository, sponge _____
- Other ___________________________ _____

What is your current method of birth control? ________________
How long have you used it? ____________________________
Do you want a prescription for birth control? ❑ No ❑ Yes
If yes, what method? __________________________________

Have you had any unprotected intercourse since your last period? ❑ No ❑ Yes

Have you ever used emergency contraception? ❑ No ❑ Yes
If yes, list date(s) ____________________________________

Do you want a prescription for emergency contraception? ❑ No ❑ Yes

Notes: ____

____

____

____

____

PRIORITIES FOR CONTRACEPTION (Check all that apply)

❑ Beneficial Side Effects
❑ Convenience
❑ Ease of Use
❑ Effectiveness Against Pregnancy
❑ Infrequent Sex
❑ Other ____________________

Primary method of choice:

____

Backup method if primary method unavailable:

____

PERSONAL / SOCIAL HISTORY

	No	Yes
Do you use tobacco?	❑	❑
Do you use alcohol or any other drugs?	❑	❑
Do you feel that alcohol or other drugs have ever compromised your sexual health?	❑	❑
Have you ever had a serious concern about your weight/food?	❑	❑
Have you ever experienced any unwanted sexual activity as a child or as an adult?	❑	❑

Comments:____

____

____

PREGNANCY HISTORY

Have you ever been pregnant? ❑ No ❑ Yes ❑ Unsure

If yes, what was the outcome?

❑ birth # _________ ❑ abortion # _______

❑ miscarriage # ________ ❑ ectopic pregnancies # _______

Complications or comments: _______________________________

____

____

SEXUAL PLEASURE AND FUNCTION

Have you experienced pain or bleeding with sexual activity? ❑ No ❑ Yes
Do you have any concerns about lubrication, orgasm, etc.? ❑ No ❑ Yes
Are there any concerns about which you would like to speak with a sexual health counselor? ❑ No ❑ Yes
Comments: ____

____

***** PLEASE STOP HERE *****

FOR OFFICE USE ONLY

Reviewed annual exam procedure ……………………………. ❑
Reviewed/demonstrated safer sex/contraceptive products…… ❑
Reviewed relaxation techniques ……………………………… ❑
Encouraged STI testing……………………………………….. ❑
Sexual Health Care brochure given…………………………… ❑
Other handouts given: ____________________________________

____

Appointment scheduled for _______________ (date) _____________ (time)

Services requested:

❑ Annual ❑ Pills ❑ IUD
❑ PAP ❑ Patch ❑ Depo-Provera
❑ STI Testing ❑ Diaphragm Fit ❑ Counseling
❑ Ring ❑ Other ________________________

Special concerns to review / address with patient at the time of visit:

____

____

____

____

____
(Signature /Title)

❑ Clinical Counselor ❑ Clinician
❑ Volunteer Peer Educator ❑ Nurse

Clinician Reviewed: _____________ (initials) _____________ (date)