UNIVERSITY OF MARY WASHINGTON

Student Health Center
1301 College Avenue Lee Hall, Room 112
Fredericksburg, VA 22401
Office: 540-654-1040 Fax: 540-654-1077

Women's Health/History Previsit Form

Patient Name: **Date:**

Date of Birth: **Preferred Phone #:**

MENSTRUAL HISTORY

First day of last menstrual period: _____

Age at first period: _____ years.

If your menstrual periods are regular; periods start every: _____ days

If your menstrual periods are irregular; periods start every:____ to ____ days (e.g.,12 to 60)

Duration of bleeding: _____ days Period flow: □ Scanty □ Moderate □ Heavy

Does bleeding or spotting occur between periods: □ Yes □ No Is pain associated with periods? □ Yes □ No □ Occasionally
If yes is it: □ Before menses □ During menses □ Both

Does bleeding or spotting occur after intercourse: □ Yes □No

GYN/Sexual History

Have you ever had a Pap Smear: □ Yes □ No **If yes**, was it: □ Normal □ Abnormal

Have you ever had intercourse: □ Yes □ No Do you currently have intercourse: □ Yes □ No

Age of first intercourse: _____ Number of sexual partners over lifetime: _____

Are your partners: □ Male □ Female □ Both Have you experienced: □Sexual abuse □ Partner violence

Do you use condoms: □ Yes □ No □ Sometimes

What type of birth control(s) have you used in the past: □ Oral Contraceptives (the pill) □ Depo Provera □ Implant □ IUD
□ Other(specify) _____ If other is Emergency contraceptive list last date taken:

Have you ever had any of the following: □ HPV □ Genital Herpes □ Genital warts □ Chlamydia □ Gonorrhea □ Syphilis □
PCOS □ Pelvic Inflammatory Disease □ Endometriosis □ Vaginal Infections □ Other (specify)_____

Have you ever been pregnant (Include ectopic pregnancies and abortion/miscarriage):
□ Yes □ No If yes how many times: _____ Have you been pregnant in the last month: □Yes □No

Have you had unprotected intercourse (without a condom or other form of birth control) since your last period: □ Yes □ No
If yes, approximate date of unprotected intercourse: _____ Did you take Emergency Contraception: □ Yes □ No

Do you think you may be pregnant: □Yes □No

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Medical History

Do you have or have you ever had any of the following (please check all that apply): OR □None

□ Arthritis
□ Diabetes:
□ Type I **age of diagnosis: _____**
□ Type II **age of diagnosis: _____**
□ High Blood Pressure
□ Blood Clots Leg/Thigh
□ Stroke or paralysis
□ Heart Disease
□ Severe Headaches with blurred vision, nausea, or dizziness
□ Gallbladder problems
□ Liver Problems
□ Chest Pain
□ Eating Disorder
□ Thyroid Disorder(specify)_____
□ Acne
□ Other(specify)_____

Social History

DO YOU CURRENTLY?

Smoke: □Never □Yes, Packs/Day:_____ □ Tobacco products □Vape □Hooka

□Former Years smoked: _____ Packs/day _____

Alcohol: □Never □Former □Yes, Drinks/week: _____

Recreational Drugs: □Never □Former □Yes Type: _____

Are you on a specific diet? □Yes □No If yes, what type of diet: _____

Do you exercise regularly? □Yes □No If yes, days/week: _____ hours/day: _____

Family History

	Yes	None	Affected Relatives (Grandparents, Parents, Siblings, Children)
Diabetes	□	□	_____
Autoimmune Disorder	□	□	_____
Heart Disease	□	□	_____
Stroke	□	□	_____
Blood Clot or Blood Disorder	□	□	_____
Gallbladder/Liver Disease	□	□	_____
Cancer (specify type)	□	□	_____
Other/specify	□	□	_____

□ Nancy Wang, MD □ Sarah Fredell, RN □ Danielle Hollandsworth, RN

Reviewed by RN:_____

Reviewed by MD/NP:_____