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 Pre-visit Form

****Please fill form out in blue or black ink, and return to the front desk. If you think you are pregnant or think you may need Emergency Contraceptive (Plan B), please request an appointment. We will get you in today.**

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

Have you ever skipped a period in a month? □ Yes □ No

Do you have more than one period in a month? □ Yes □ No

How many days does your period last? _____ 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

Age of first intercourse: _____

What type of birth control(s) do you use or have used in the past: □ Oral Contraceptives (the pill) □ Depo Provera □ Implant □ IUD □Condoms
Other(specify) _____

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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Risk Assessment

Within the past 5 (five) years have you engaged in (check all that apply):

☐ Sex with male *If yes:* ☐ Anal ☐ Oral ☐ Vaginal

☐ Sex with female *If yes:* ☐ Anal ☐ Oral ☐ Vaginal

☐ Sex with transgender person ☐ Anal ☐ Oral ☐ Vaginal

☐ Sex with anonymous partner

☐ Sex with a person who injects drugs

☐ Sex without using a condom

☐ Sex with more than 3 partners in the **last year**

☐ Sex with a person who is HIV+

☐ ***Women only-*** sex with a man that has sex with other men

☐ Have you ever been, or are you currently in, an abusive romantic/sexual relationship?

☐ Sex while intoxicated and/or high on drugs

☐ Injected Drugs *If yes*: ☐ Shared injection equipment

☐ Sex with a person of unknown HIV status

☐ Sex with hemophiliac or transfusion recipient

☐ Sex with a person who exchanges sex for money/drugs

☐ Exchanged sex for drugs/money/or other items

Other Risk:

☐ Have a prescription for any HIV- related PrEP or PEP

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
□ Depression/Anxiety
□ Severe Headaches with blurred vision, nausea, or dizziness
□ Gallbladder problems
□ Liver Problems
□ Chest Pain
□ Eating Disorder
□ Thyroid Disorder(specify)_____
□ Acne
□ self or family history of breast or reproductive cancer

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

Reviewed by: _____ **Date:**_____