

## Columbus State University GYN History

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
909 \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

What is the **1st Day** of your **Last Period**? \_\_\_\_\_

Age your period began: \_\_\_\_\_ Periods are: Regular Irregular How many days do they last? \_\_\_\_\_

Painful periods: Rate 0-5 (with 5 being the worst) \_\_\_\_\_

Have you ever been sexually active? Yes No

Your sexual partners are: Men Women Both

Number of sexual partners: **In the last month** \_\_\_\_\_ **In the last 6 months** \_\_\_\_\_

When was your last sexual encounter? \_\_\_\_\_

Last encounter was with: Male Female

Type of sex you have had: Vaginal Oral Anal

Do you use condoms or other protection when having sex? Never Sometimes Always

Have you taken Plan B? Yes No Date: \_\_\_\_\_

Have you ever been pregnant? Yes No

Current form of birth control: \_\_\_\_\_ Problems with this birth control? Yes No

Date of last Pap (usually not done until age 21 years): \_\_\_\_\_ Results: Normal Abnormal

Where was it done? \_\_\_\_\_

Do you have a history of: **Migraine headaches**: Yes No **High blood pressure**: Yes No

**Blood clots in your body**: Yes No **Sexual or physical abuse**: Yes No

**Receiving HPV vaccines**: Yes No

Have you ever had a Sexually Transmitted Infection? Yes No Date(s) of infection: \_\_\_\_\_

Name(s) of infection(s): \_\_\_\_\_

Are you experiencing symptoms now? Yes No

What are they? \_\_\_\_\_

Have any of your **partners** ever had a Sexually Transmitted Infection? Yes No Unsure

**If yes**, name of infection: \_\_\_\_\_

Have you been tested for HIV in the past 6 months? Yes No

Do you have a family history of female cancers? Yes No