

**Northern Illinois University
Health Services
Division of Student Affairs
815-753-1311**

Last Name _____ **First Name** _____

ID# _____ **Gender** ____ **DOB** _____

Women's Health History

Date _____

MENSTRUAL AND GYNECOLOGICAL HISTORY	
First day of last menstrual period:	Date of last pelvic exam:
Your age when periods began: How often do you have a period? Every ____ days (Count from first day of period to first day of next)	Date of last Pap smear: Have you ever had an abnormal Pap result? If yes, explain
Flow: Light Moderate Heavy	History of abnormal vaginal spotting or bleeding? If yes, describe
How many days does period last?	Do you have premenstrual syndrome (PMS)? If yes, describe
Cycle: Regular Irregular	History of breast problems i.e. lumps, nipple discharge? If yes, describe
Cramps: None Mild Moderate Severe	

CONTRACEPTIVE HISTORY

Have you used hormonal contraception (i.e. birth control pills)? Yes No Dates: From _____ To _____

Name of method _____ Why did you use a hormonal method? _____

Other methods of birth control used in the past _____ Problems? _____

Current birth control methods used by you or your partner _____ Problems? _____

Which method would you prefer now?

PREGNANCY HISTORY

Number of pregnancies _____ Number of living children _____ Ages _____

Number of abortions: _____ Dates _____ Number of miscarriages: _____ Dates _____

HEALTH HISTORY

List any surgeries, including **Cryo** or **LEEP** surgery, and when _____

Medication you are taking regularly and why _____

Are you currently on a special diet? YES NO Type _____

List any known allergies to medication, latex or rubber _____

Signature

Date

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HAVE YOU EVER HAD	YES	NO	WHEN?
Heart Disease			
High Blood Pressure			
Stroke			
Blood Clot			
Cancer – Type:			
PID: infection of ovaries, tubes			
STI: Gonorrhea, Chlamydia, Syphilis, Herpes, Genital Warts (condyloma)			
HIV/AIDS			
Headaches – Severe and/or frequent			
Emotional Problems/Depression			
Eating Disorder			
Drug Use			
Alcohol Use			
Tobacco Use			
Mono			
Epilepsy			
Diabetes			
Blood Test for Cholesterol Level			Normal Elevated
Other Serious Illnesses			

FAMILY MEDICAL HISTORY (Parents, Siblings, Children, Grandparents, Aunts, Uncles, Cousins)			
Cancer Type:			
Heart disease, stroke			
Genetic disease/disorder			
Diabetes			
Elevated cholesterol			
Other serious illness or condition			

Are there any changes in your health since your last visit? YES NO If yes, please describe

Do you have any concerns regarding your health or contraception needs you want to discuss today? YES NO
Describe:

Signature _____ Date _____