

**CSUSM STUDENT HEALTH SERVICES
INITIAL GYNECOLOGICAL HISTORY**

DATE ___/___/___

LAST NAME _____ FIRST NAME _____

STUDENT I.D.# _____ ADDRESS _____

DATE OF BIRTH _____ PHONE () _____ CELL/BUS () _____

YES NO (Please check the appropriate box)

PREVIOUS EXAMS

- Have you ever had a gynecological (pelvic) exam or PAP smear before?
If yes, where? _____
When was your last PAP smear? _____
- Have you ever had an abnormal PAP?
- Have you attended the GYN Orientation here?
- Have you viewed the PAP video and/or met with the Health Educator for a PAP consult?

MENSTRUAL HISTORY

- Date last period began ___/___/___
Age menses started: _____ years
Days from first day of one period to first day of next: ____ (before birth control pills, if you take)
How many days does your menstrual bleeding typically last? _____
- Do you use more than 5 pads/tampons a day?
- Have your menstrual cycles been frequently irregular? (before birth control pills, if you take)
If yes, what is the longest time you have gone between periods? _____
- Did your mother take any medications to prevent miscarriage while pregnant with you? (ie DES)
- Have you recently been bothered by:
- Bleeding between periods or after intercourse
- Mid-cycle pains
- Vaginal discharge, itching, irritation or sores
- Burning with urination
- Before or during your period, are you troubled by:
- Depression/Anxiety
- Breast tenderness/fullness
- Weight gain (more than 5 lbs.)
- Ankle swelling
- Headache
- Severe cramping

SEXUAL HISTORY

- Have you ever had intercourse? If yes, age at first intercourse: _____
When was the last time you had intercourse? _____
How long have you been with your present partner? _____
Approx. number of different partners during your lifetime? _____ Number during the last 6 mos. _____
- Are you satisfied with your current sexual life?
- Do you have any pain or discomfort during intercourse?
- Do you have concerns about sexuality, sexual assault, domestic violence or sexually transmitted infections that you wish to discuss?
- Are your sexual partners men, women or both? (please circle)

PREGNANCY HISTORY

- Have you ever been pregnant?
Total number of pregnancies? _____
Number of miscarriages _____ What year(s) _____
Number of live births _____ What year(s) _____
Number of abortions _____ What year(s) _____
- Are you currently pregnant?

OVER

**CSUSM STUDENT HEALTH SERVICES
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DATE ____/____/____

CONTRACEPTIVE HISTORY Please indicate which contraceptive methods you have used:

- | | |
|---|--|
| <input type="checkbox"/> "Pill" | <input type="checkbox"/> Norplant |
| <input type="checkbox"/> Condoms | <input type="checkbox"/> IUD |
| <input type="checkbox"/> Spermicide | <input type="checkbox"/> Natural Family Planning |
| <input type="checkbox"/> Sponge | <input type="checkbox"/> Nuva Ring |
| <input type="checkbox"/> Diaphragm / Cervical Cap | <input type="checkbox"/> Other |

YES NO (Please check the appropriate box)

- What is your current method (& brand, if on the pill) _____
How long have you used this method? _____
- Are you dissatisfied with your current method?
If yes, what method would you like to use? _____
- Have you had any problems or pregnancies while using any birth control method?
If yes, which method(s)? _____
- Does your partner use condoms? If yes, how often? Always Usually Sometimes Never

PAST HISTORY Please indicate any of the following problems which you have had:

- | | | |
|--|---|--|
| <input type="checkbox"/> Blood clots in veins or lungs | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Infection in tubes/uterus (PID) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tubal (ectopic) pregnancy |
| <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Vaginal infection |
| <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Bladder or kidney infections |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Uterine or other cancer |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Abnormal PAP smear | | |

YES NO (Please check the appropriate box)

- Have you ever had a sexually transmitted disease (check all that apply):
 Genital warts Herpes Chlamydia Gonorrhea Syphilis HIV/AIDS Other
- Are you currently taking any medications? If yes, what? _____
- Do you have allergies or reactions to any medications? If yes, what? _____
- Have you ever been hospitalized or had another serious illness?
If yes, please list reason and dates.

HEALTH PROMOTION

- Do you examine your breasts monthly?
- Have you ever had a mammogram? If yes, when? _____ Results: Normal Abnormal
- Do you exercise 3 or more times a week for 20 or more minutes?
- Have you had your cholesterol checked? What was the level _____ Normal (<200)
- Do you smoke? If yes, how many cigarettes per day? _____ For how long? _____ years
- Do you feel or does anyone close to you feel that you have a problem with alcohol or drugs?

FAMILY HISTORY Has a parent, grandparent, brother or sister had any of the following?

- Cancer
- Heart disease
- High cholesterol
- Diabetes
- Blood clots
- Other inheritable diseases

Last Name: _____ First Name: _____
Student I.D.# _____