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DE ANZA COLLEGE STUDENT HEALTH SERVICES

Annual GYN Health History Questionnaire

Name _____ Date of Birth: _____ Student ID#: _____

Reason for visit _____

Allergies: _____ Current Medication: _____

Do you have any of the following problems? (Please mark all that apply)

- ☐ *Painful periods*
- ☐ *No periods*
- ☐ *Spotting*
- ☐ *Heavy flow*
- ☐ *Irregular periods*
- ☐ *Painful intercourse*
- ☐ *Lumps in breast/breast cancer*
- ☐ *Ovarian problems*
- ☐ *Blood clotting*
- ☐ *Vaginal bleeding/discharge/itching*
- ☐ *Gallbladder disease*
- ☐ *Liver disease*
- ☐ *Thyroid disease*
- ☐ *Migraine headaches*
- ☐ *High blood pressure*
- ☐ *Heart condition*
- ☐ *Diabetes*
- ☐ *Kidney disease*
- ☐ *Asthma*
- ☐ *Depression*
- ☐ *Anemia*
- ☐ *Varicose veins*
- ☐ *Uterine problems*
- ☐ *High cholesterol*

GYNECOLOGIC HISTORY:

Age you started your periods? _____

Do you have any problems with your period? ◯ Yes ◯ No

If yes, please explain: _____

When was the **first** day of your last period? _____

Do you have your period once per month? ◯ Yes ◯ No

If not, how often? _____

How long does your period usually last? _____

PREGNANCY HISTORY:

Number of pregnancies: _____

Number of births: _____

Number of abortions: _____

Number of miscarriages: _____

Were there any problems with your pregnancies? ◯ Yes ◯ No

If yes, please explain: _____

Did your mother take DES when she was pregnant with you? ◯ Yes ◯ No

SOCIAL HISTORY:

Do you drink alcohol? ◯ Yes ◯ No

Indicate type and frequency: _____

How much per day: _____

Do you use tobacco (including e-cig)? ◯ Yes ◯ No

Indicate type and frequency: _____

How many per day: _____

Do you use recreational drug? ◯ Yes ◯ No

Indicate type and frequency: _____

Date of last well woman exam: _____

Date of last pap smear: _____

Result: _____

Do you perform breast self-exams? ◯ Yes ◯ No

How often? _____

Have you ever had a sexually transmitted infection? ◯ Yes ◯ No

If yes, please indicate type: _____

FAMILY HISTORY:

Do you have any history of cancer in your family? ◯ Yes ◯ No

If yes, indicate type and family member: _____

SEXUAL HISTORY:

Are you sexually active? ◯ Yes ◯ No

Type of contact: ☐ Oral sex / ☐ Vaginal sex / ☐ Anal sex

How many sexual partners have you had in your life? _____

Were they: ◯ Male / ◯ Female / ◯ Both

Have you had more than one partner this year? ◯ Yes ◯ No

Condom use: ◯ Always / ◯ Sometimes / ◯ Never

Have you been screened for STI's? ◯ Yes ◯ No

CONTRACEPTION HISTORY:

What methods of birth control (if any) are you currently using or have used in the past? _____

Are you having problems with this method? ◯ Yes ◯ No

Do you any question that you would like to address today? ◯ Yes ◯ No

Please indicate: _____

Patient Signature:	**Date:**	**Clinician Signature:**	**Date:**