ILLINOIS
McKinley Health Center

*place label here*

Name:

UIN:

Date:

# Women's Health Patient Questionnaire

## A. MENSTRUAL HISTORY

Age of first period _____

Periods usually come every _____ days.

Periods usually last for _____ days.

Was the last menstrual period normal in length and flow: ☐ Yes ☐ No

Do you have cramps with your period? ☐ Yes ☐ No

Do you take any medication for menstrual pain? ☐ Yes ☐ No
If yes, what_____

Does your pain interfere with work or class? ☐ Yes ☐ No

Number of pads/tampons used on heaviest day: _____

Do you have bleeding between your periods? ☐ Yes ☐ No

## B. CONTRACEPTIVE HISTORY

☐ Not applicable *(move to next section)*

Have you used any of the following? (C*heck all that apply)*

☐ Abstinence
Barrier method: ☐ Condoms 100% ☐ Diaphragm
Hormonal: ☐ Pills ☐ Shot ☐ Implant ☐ Ring ☐ Patch
IUD: ☐ Skyla ☐ Mirena ☐ ParaGard
☐ Spermicide
☐ Emergency contraception
Other_____

What is your current method of birth control?_____
_____

Have you had sex without using any birth control method since your last menstrual period? ☐ Yes – date_____☐ No

## C. SEXUAL HISTORY

Have you engaged in sexual contact (oral, vaginal, anal) with:
☐ men ☐ women ☐ both ☐ neither

At what age did you become sexually active?_____

How many partners in the last 12 months?_____

Do you have a current sexual partner? ☐ Yes ☐ No
How long have you been with your current sexual partner?_____

Have you ever been diagnosed with or treated for any of the following sexually transmitted diseases? *(check all that apply)*
☐ None
☐ chlamydia ☐ genital herpes ☐ oral herpes
☐ genital warts ☐ hepatitis ☐ syphilis ☐ gonorrhea
Other_____

How do you protect yourself against STDs? *(check all that apply)*
☐ abstinence ☐ oral barriers ☐ condoms
☐ long-term monogamy ☐ STD testing for self
☐ STD testing of contact/partner
Other_____

Have you ever experienced any unwanted sexual contact as a child or an adult? ☐ Yes ☐ No

Have you ever had concerns about physical or emotional violence in a relationship? ☐ Yes ☐ No

## D. GYNECOLOGIC RELATED HISTORY

Have you ever had a pelvic exam? ☐ Yes ☐ No

Have you completed the HPV vaccine series (Gardasil)?
☐ Yes ☐ No Comments_____

Have you ever had any of the following?
☐ Breast abnormalities
☐ Abnormal amount of hair growth (facial, chest, abdomen)
☐ Endometriosis
☐ Ovarian cysts
☐ Fibroids
☐ Pelvic Inflammatory Disease
☐ Abnormal Pap Smear _____
_____
_____
_____

## E. PREGNANCY HISTORY

Have you ever been pregnant? ☐ Yes ☐ No
If yes, what was the outcome?
☐ Birth #_____date_____
☐ Termination #_____date_____
☐ Miscarriage #_____date_____
☐ Tubal pregnancy #_____date_____

Complications/comments_____
_____

**Clinician Comments:** _____

_____

_____

_____

***(over)***

ILLINOIS
McKinley Health Center

*place label here*

Name:
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**Women's Health Patient Questionnaire (continued)**

## F. PATIENT MEDICAL HISTORY

Have you ever been diagnosed with or treated for any of the following:

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Acne | ☐ | ☐ | Migraines | ☐ | ☐ | High Blood Pressure | ☐ | ☐ |
| Anemia | ☐ | ☐ | Severe Headaches | ☐ | ☐ | Heart Abnormalities | ☐ | ☐ |
| Asthma | ☐ | ☐ | Eating Disorder | ☐ | ☐ | Mono in the last 6 months | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Depression | ☐ | ☐ | Liver Disease/Hepatitis | ☐ | ☐ |
| Cancer | ☐ | ☐ | Blood Transfusion | ☐ | ☐ | Kidney Disease | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | Bleeding Disorder | ☐ | ☐ | Urinary Tract Infections | ☐ | ☐ |
| Thyroid Disorder | ☐ | ☐ | Blood Clots in legs, lung, brain | ☐ | ☐ | #_____in past year | | |
| Seizure/Epilepsy | ☐ | ☐ | Inflammation of leg veins | ☐ | ☐ | Other_____ | | |

List past surgeries/hospitalizations_____

_____

## G. FAMILY HISTORY

Were you adopted? ☐ Yes ☐ No

Indicate below any family member (parents, grandparents, siblings, children) with any of the following:

| | Yes | No | Family member / age diagnosed: | | Yes | No | Family member / age diagnosed: |
|---|---|---|---|---|---|---|---|
| Stroke | ☐ | ☐ | _____ | Breast Cancer | ☐ | ☐ | _____ |
| Heart Attack | ☐ | ☐ | _____ | Ovarian Cancer | ☐ | ☐ | _____ |
| Blood Clots | ☐ | ☐ | _____ | Uterine Cancer | ☐ | ☐ | _____ |
| Elevated Cholesterol | ☐ | ☐ | _____ | Colon Cancer | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | _____ | Other_____ | | | |
| High Blood Pressure | ☐ | ☐ | _____ | | | | |

## H. HEALTH HABITS / WELLNESS HISTORY

Do you use tobacco products? ☐ Yes ☐ No If yes, how many per day?_____

Do you sometimes drink beer, wine or other alcoholic beverages? ☐ Yes ☐ No

If yes, how many times in the past year have you had 4 or more drinks in a day?_____

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?_____

Do you text while driving? ☐ Yes ☐ No

Do you wear a helmet when riding a bike or motorcycle and/or while rollerblading or skateboarding? ☐ Yes ☐ No ☐ N/A

Do you exercise routinely? ☐ Yes ☐ No If yes, how often?_____

What is your selected food pattern? ☐All food groups ☐Vegetarian ☐Lacto-ovo-vegetarian ☐Vegan ☐Other_____

**Patient Signature**_____ **Date**_____

**Clinician Comments:** _____

_____

_____

**Clinician Signature**_____ **Date**_____