ILLINOIS
McKinley Health Center

place label here

Name:

UIN:

Date:

Women's Health Patient Questionnaire

MENSTRUAL HISTORY

Are your periods usually regular (every 24-38 days)?
☐ Yes ☐ No ☐ NA _____

Sexual Health History

What is your gender identity? _____

Gender assigned at birth? ☐ Female ☐ Male

Have you ever engaged in sexual contact (oral, vaginal, anal):
☐ Yes ☐ No
Are you currently sexually active? ☐ Yes ☐ No
Partner(s)is/are
☐ Male ☐ Female ☐ Other _____

Have you ever been diagnosed with or treated for any of the following sexually transmitted infections? *(Check all that apply)*
☐ chlamydia ☐ gonorrhea ☐ genital herpes ☐ oral herpes
☐ genital warts/HPV ☐ hepatitis B/C ☐ syphilis ☐ HIV
☐ None

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

GYNECOLOGIC RELATED HISTORY

History of breast, ovarian or uterine abnormalities?
☐ Yes ☐ No
Have you completed the HPV (Gardasil/Cervarix) vaccine series?
☐ Yes ☐ No ☐ Unsure
Have you ever had an abnormal pap or HPV?
☐ Yes ☐ No ☐ Never had a Pap Test
Have you had gynecological surgeries/hospitalizations?
☐ Yes ☐ No

CONTRACEPTIVE HISTORY

☐ Not applicable *(move to next section)*

Which birth control method are you **currently** using?
(Check all that apply)
☐ None ☐ Abstinence ☐ Withdrawal
☐ Natural Family Planning/Track Cycles
☐ Condoms ☐ Spermicide ☐ Diaphragm ☐ Pills
☐ Shot ☐ Implant ☐ Ring ☐ Patch ☐ IUD _____
☐ Emergency contraception ☐ Sterilization

PREGNANCY HISTORY

Have you ever been pregnant? ☐ No
☐ Yes Year(s):_____

Patient Medical History

Have you ever had:

☐ Migraines
☐ Severe Headaches
☐ Eating Disorders
☐ Anemia
☐ PCOS
☐ Diabetes
☐ Thyroid Disorder
☐ Heart Problems
☐ High Blood Pressure/High Cholesterol
☐ Blood Clots or Bleeding Disorder
☐ Urinary Tract Infection(s) in the last year _____
☐ Other:_____

☐ Liver or Kidney Disease
☐ Acne
☐ Anxiety and/or Depression
☐ Seizure/Epilepsy
☐ Cancer
☐ Ulcerative Colitis/Crohn's

List past surgeries/hospitalizations:
_____
_____
_____

FAMILY HISTORY

Were you adopted? ☐ Yes ☐ No

Indicate below any family member (parents, grandparents, siblings, children) with any of the following:
Family Member and Age Diagnosed:
☐ Stroke_____ ☐ Heart Attack_____
☐ Blood Clots/Bleeding Disorders_____
☐ Diabetes_____ ☐ Breast Cancer_____
☐ Ovarian Cancer_____ ☐ Uterine Cancer_____
☐ Colon Cancer _____
Other Please Specify: _____

Patient Signature: _____

Date: _____

Clinician Comments:_____

_____

Clinician Signature:_____

Date_____