

**NAZARETH COLLEGE Health Services
Women's Health History Form**

NAME: _____ **Date of Birth:** _____

Telephone # () _____

Are there any health care problems or concerns you have today?

Please list all medical/ physical and mental health conditions/previous surgery:

Please list all medications that you take regularly including over the counter medications and vitamins: _____

Please list all allergies to medications: _____

How many periods have you had in the last 12 months? _____

Are your periods regular? Yes no Do you examine your breasts? Yes No

Have you ever had a Pap smear? Yes No Date of last Pap _____

Have you ever had an abnormal Pap? Yes No Date _____

If yes treatment? _____

Have you had the HPV vaccine series? Yes No If so circle number received: 1 2 3

Do you consider yourself to be: heterosexual/lesbian/bisexual ?

Age of first intercourse? _____

Do you use condoms or other barrier protection during sexual activity? Yes No

Name of contraception _____

Have you ever had a sexually transmitted infection? Yes No If yes, please name

Have you even been forced to have sexual contact against your will? Yes No

Have you even been in a relationship where you were physically hurt or threatened? Yes
No

Do you regularly wear a seat belt? Yes No

Do you use tobacco (smoke, chew)? Yes No

Are you depressed or suicidal? Yes No

Are you concerned that you are abusing drugs or alcohol? Yes No

Does your diet provide a variety of milk products? Yes No

How often do you exercise? _____ days per week _____ minutes per day

Does concern about your weight or food interfere with your life? Yes No

Do you compensate for eating with purging or laxative use? Yes No

I certify that my responses are complete and true to the best of my knowledge. Signature _____ Date _____

(For office use only)

Reviewed:

Changes: _____ Initials _____ Date _____

Changes: _____ Initials _____ Date _____

Changes: _____ Initials _____ Date _____