CONTRACEPTIVE HEALTH HISTORY FORM

ALL INFORMATION IS CONFIDENTIAL

Radford Student Health Service serves women of all ages and sexual orientations (lesbian, heterosexual, and bisexual). We have tried to make this form as comprehensive as possible, realizing that some questions will not be pertinent to every woman's particular circumstances. If you have trouble answering any of the questions, the interviewer will be glad to help you.

Name:_____ Birth date____/____/____ Age:_____
Last First Middle

Date:_____ RU Student ID # _____

PERIODS-MENSTRUAL HISTORY:
First day of my last period: ____/____/____
My periods come about every_____days. My periods usually lasts _____ days.
My flow is: Scanty_____ Moderate_____ Heavy_____ Painful_____.
I have bleeding: Between periods_____ After sex_____.
I began having menstual periods at age_____.
I have/have had irregular periods_____No _____Yes Explain:_____.

I HAVE OR HAVE HAD:
A Pap Smear before _____No _____Yes
Blood clots in my legs/lungs _____No _____Yes
Sexually Transmitted Infections _____No _____Yes
Stroke or paralysis _____No _____Yes
Migraines _____No _____Yes
Breast cysts or lumps or disease _____No _____Yes
Infection in tubes, ovaries, uterus _____No _____Yes
Abnormal Pap smear _____No _____Yes
Female or abdominal surgery _____No _____Yes

HPV Vaccine history (please check one):
☐ I received only one HPV vaccine
☐ I received only two HPV vaccines
☐ I received all three HPV vaccines
☐ I have not received the HPV vaccine

PREGNANCIES
Ever pregnant:_____Yes _____No Number of pregnancies_____. Are you breast feeding now?_____

LIST PREGNANCIES:

Date Preg. ended	Live births	Still born	Abortion	Miscarriage	#weeks preg	Delivery Method	Complications (toxemia, etc)

BIRTH CONTROL
I have never had sex_____ I am sexually active_____ I have a new sex partner_____YES _____NO

Age of first intercourse_____ Number of sex partners to date_____ How long with present partner?_____

Put an X after the methods you have used or are using now.

	Now	Past	How long used?	Date of use	Problems?	Why stopped?
Pills Name:_____						
IUD Name:_____						
Diaphragm/jelly/cream						
Condom (rubbers)						
Foam/jelly/cream alone						
Natural Family Planning						
Depo-Provera						
OrthoEvra (Patch)						
NuvaRing						
Nexplanon						

I have reviewed the above information with the patient_____
Health Care Provider's Signature

Your medical records will be retained for 10 years after your last visit.
After that time they will be destroyed.

RUSH **GYN**
EMPI_____