

GYNECOLOGICAL AND SEXUAL HEALTH QUESTIONNAIRE

Student Health Services, SUNY New Paltz

Name _____

Date _____

Date of Birth _____

Marital Status _____

PAST MEDICAL HISTORY: Do you have or have you ever had?

- | Y | N | | Y | N | | Y | N | |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Migraine Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection | <input type="checkbox"/> | <input type="checkbox"/> | Breast Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression and/or anxiety | <input type="checkbox"/> | <input type="checkbox"/> | Weight Changes | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal Infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> | Varicose Veins | <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots in legs/lungs | <input type="checkbox"/> | <input type="checkbox"/> | Chlamydia |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Genital Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | Severe Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Acne | <input type="checkbox"/> | <input type="checkbox"/> | Syphilis |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Nausea | <input type="checkbox"/> | <input type="checkbox"/> | Genital Warts/HPV |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Constipation/Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | HIV |
| <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder problems | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Other Sexually Transmitted |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease or Infection | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia | | | Infections |
| | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | Other |

FAMILY HISTORY: Has anyone in your family had any of the following conditions?

- | Y | N | | Y | N | | Y | N | |
|--------------------------|--------------------------|----------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Migraine Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Ovarian Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack/Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Breast Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease or Infection | <input type="checkbox"/> | <input type="checkbox"/> | Other |

If yes to any of the above, please explain _____

Have you been hospitalized? Y N If yes: dates, why, and facility _____

Have you had any operations? Y N If yes: dates, type, and facility _____

Are you on any medications now? Y N If yes: names, doses, and prescriber _____

Allergies to any medications? Y N If yes, names _____

Do you smoke? Y N Do you drink alcohol? Y N Do you use drugs? Y N

GYNECOLOGIC HISTORY

Age when had first period _____ How many days is your period _____
How many days between periods _____ Are your periods regular? Y N
Are your periods painful? Y N First day of last period _____
Date of last sexual contact _____ How old were you when you first had sex? _____
How many partners have you had? _____ Your partners are: male female both
Have you been a victim of sexual assault? Y N Type of sex you have had: oral vaginal anal
Are you concerned about having been exposed to a sexually transmitted infection (STI)? Y N
Do you want STI testing? Y N Have you had the Gardasil vaccine? Y N
Do you use condoms? always usually sometimes Never

CONTRACEPTION USED IN THE PAST TWO YEARS

Method	Date Started	Date Stopped	Reason Stopped

If you are taking birth control pills, have you had any side effects (e.g. headaches, missed periods)? Y N
Last Pap test date _____ Have you ever had an abnormal Pap? Y N
Any bleeding or pain with intercourse? Y N Any infections in your uterus or tubes? Y N
Have you had gynecologic surgery? Y N If yes, please explain _____

Any lumps or cysts in your breasts? Y N Do you examine your breasts? Y N
Have you had breast surgery? Y N If yes, please explain _____

PREGNANCY HISTORY

of pregnancies _____ # of live births _____ # of miscarriages _____ # of terminations _____ # of children _____
Any problems with pregnancies, deliveries, or after a termination? Y N If yes, please explain _____

