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? (*Check 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)

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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**______________________