

PAP HEALTH HISTORY FORM

NAME _____ BIRTHDATE _____ DATE _____

GYNECOLOGICAL HISTORY

1. _____ First day of your last menstrual period
2. _____ How many days does your period last?
3. _____ How many days between periods?
4. _____ Age when you started your period
5. _____ Do you currently have bleeding between periods?
6. _____ Do you currently have bleeding or pain during intercourse?
7. _____ Do you currently have any unusual vaginal itching, discharge or odor?
8. _____ Do you currently have pelvic pain?
9. _____ When was your last pap smear?
10. _____ Have you had an abnormal pap smear? If yes, explain _____
11. _____ Do you do self breast exams?
12. _____ Have you had a mammogram?
13. _____ Have you had the HPV vaccine?

SEXUAL HISTORY

1. _____ Are you currently sexually active? If yes, with males, females, or both? _____
2. _____ Age you first had intercourse
3. _____ Have you had contact with a bisexual male or IV drug user?
4. _____ Have you had more than one sexual partner since your last pap smear?
5. _____ Are you using contraception? If yes, what type? _____

PREGNANCY HISTORY

1. _____ Number of living children
2. _____ Number of miscarriages
3. _____ Number of terminations

DISEASE AND INFECTIONS (Check any you have had)

- Chlamydia Gonorrhea Herpes Trichomonas Genital Warts/HPV HIV
Syphilis Hepatitis Other, _____

SURGERIES (Check any you have had)

- Colposcopy Leep Cervical Cryotherapy Hysterectomy D&C Laparoscopy
Tubal ligation Removal of tubes or ovaries Other, _____

MEDICATIONS

List all medication you are currently taking, including herbal medications and supplements:

MEDICAL HISTORY (Check any you have had)

- High blood pressure Heart disease Blood clots in legs or lungs Stroke Migraines
Do you smoke? Yes No

FAMILY HISTORY (Check if any family members have had)

- High blood pressure Heart attack Stroke Blood clots Cancer

PATIENT'S SIGNATURE _____ DATE _____