# Women's Health Update

### A. Menstrual History
- First day of last period: ____________
- Was it normal in length and flow? □ Yes □ No
  - Comments: ____________
- Do you have bleeding between periods? □ Yes □ No
  - Comments: ____________

### B. Contraceptive History
- ☐ Not applicable (move to section C)
- Current method(s) of birth control (condoms, pills, shot, IUD, etc.): ____________
- Have you had sex without using birth control since your last period? □ Yes - date ____________ □ No

### C. Gynecologic History
- Date of most recent pelvic exam: ____________ □ N/A
- Did this include a Pap Smear? □ Yes □ No □ Unsure
- When is the last time you tested for sexually transmitted infections? ____________ mth/yr □ Never
- Have you been diagnosed with, treated for, or exposed to a sexually transmitted infection in the last six months? □ Yes □ No □ Unsure
  - Comments: ____________
- Have you used emergency contraception/Plan B in the last 3 months? □ Yes - date ____________ □ No

### D. Sexual History
- ☐ Not applicable (move to section E)
- Number of lifetime sexual partners: ____________ Number in last six months: ____________
- Are you currently in a sexual relationship? □ Yes □ No
  - Is this an exclusive/monogamous relationship? □ Yes □ No
    - Comments: ____________
  - How long have you been in this relationship? ____________

### E. Medical History
Please list any new diagnoses/treatments and recent surgeries/hospitalizations, if any: ____________

### F. Family History
Please list any recent changes in your family history, if any, and indicate family member: ____________

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Patient Signature: ____________ Date: ____________
Clinician Comments: ____________

Clinician Signature: ____________ Date: ____________