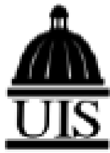

University of Illinois Springfield
UIS Health Services
(217) 206-6676

WOMEN'S HEALTH UPDATE

place label here
Name:
UIN:
Birth date:
Date:

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: ______________________

____

____

____

Patient Signature: ______________________ Date: ______________

Clinician Comments: ______________________

____

Clinician Signature: ______________________ Date: ______________

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