

**Vanderbilt Student Health Center
Health History Form**

MR# _____

Name: _____

Date: _____

Phone: _____

SS#: _____

All records are **CONFIDENTIAL**. Information is released only with your written permission or as required by law.

What is the main purpose of your visit? 1st Annual Annual Birth Control Options STD Screen Other

Medical History

Have you ever been diagnosed or treated for any of the following:

	NO	YES		NO	YES		NO	YES
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Seizure/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Infections	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Any operations?	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

Medications being taken: _____

List all **allergies**: _____

Do you smoke? Yes No How much? _____ Do you use alcohol? Yes No How much? _____

Do you use drugs? Yes No What kind? _____ How often? _____

Are you satisfied with your current weight? Yes No How often do you go on a diet? _____

Do you exercise? Yes No Have you tried to control your weight by vomiting, diet pills, or not eating? Yes No

Family History

Were you adopted? Yes No

Have any of your immediate family members had any of the following:

	Relationship	Onset Age
Blood Clot Disorder	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Heart Disease/Attack	_____	_____
High Blood Pressure	_____	_____
High Cholesterol	_____	_____
Stroke	_____	_____

Sexual History

How many sexual partners have you had? _____

Are you: Married/Partnered Single Divorced

Are your partners: men women both

At what age did you become sexually active? _____

If presently monogamous, how long? _____

Have you ever been diagnosed or treated for an STD? Yes No

Have you discussed STD risk with contacts/partners? Yes No

How do you protect yourself against STDs? (Check all that apply)

Abstinence Condom Oral Barriers Spermicidal

Long-term mutual monogamy

Have you experienced pain or bleeding with sexual activity?

Yes No

Have you felt verbally or physically threatened in your current or past relationships? Yes No

Annual Exam

Is this your first exam? Yes No

Any concerns: _____

Any abnormal Paps? No Yes, dates _____

Date of last Pap _____ Result _____

Have you had the HPV vaccine? Yes No

How often do you do self-breast exam? _____

Menstrual History

Age when first started period: _____

How often do you have a period? 28 days 30 days other _____

How many days of bleeding each cycle: _____

Days of heavy bleeding: _____

Do you experience severe menstrual cramps? Yes No

Contraceptive History

Have you used any of the following:

Abstinence Yes No

Barrier Method (condom, diaphragm, etc.) Yes No

Hormonal: pill, shot, Ring, Patch Yes No

Spermicidal: foam, gel, film, suppository Yes No

What is your current method of Birth Control? _____ For how long? _____

Do you want a prescription for Birth Control? Yes No If yes, what method? _____

Have you ever used emergency contraception? Yes No

Have you had unprotected intercourse since your last period? Yes No If yes, dates: _____

Please write down any particular questions you have about the use of birth control: _____

Pregnancy History

Have you ever been pregnant? Yes No Unsure

If yes, what was the outcome? # of abortions _____

of births _____ # of miscarriages _____

Tubal pregnancy _____

Complications of pregnancy? _____

Could you currently be pregnant? Yes No Unsure