IOWA STATE UNIVERSITY
Thielen Student Health Center

Thielen Student Health Center
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Gynecological History Form

DO NOT SCAN

The information on this form is confidential. We ask these questions so we can provide you with comprehensive care and counseling.

Patient Name: _____

Age: _____

What brings you to this appointment today: _____

Menstrual History:

When was the FIRST day of your last period:_____ Was it normal? Yes ☐ No ☐

At what age did you start your periods:_____

How often do you get your periods:_____

Are you having any problems with you periods now:_____

Pap History: please complete if you are age 21 or older

When was your last Pap Smear: _____

Have you had an abnormal pap? Yes ☐ No ☐

What follow-up was done for your abnormal pap:_____

Gynecological History: Have you ever had any of the following? Please check the appropriate box(s).

☐ Gynecological Surgery

☐ Sexually Transmitted Infection (STI)

☐ Have you received the HPV vaccine (Gardasil)

☐ History of Sexual Assault

☐ Migraine Headaches

☐ Blood Clot (deep vein thrombosis)

Gender Identity:

What is your gender identity:_____

What sex were you assigned at birth: Female ☐ Male ☐

Sexual History:

Have you ever had sexual intercourse? Yes ☐ No ☐

How many sexual partners have you had in the last 6 months:_____

Have your sexual partners(s) been: Male ☐ Female ☐ Both ☐

Are condoms used: Never ☐ Sometimes ☐ Always ☐

Would you like to discuss sexually transmitted infection (STI) screening options? Yes ☐ No ☐

Contraceptive use:

If applicable, what contraceptive method(s) do you currently use: _____

Please describe any concerns with this method(s): _____

Obstetrical History:

Have you ever been pregnant: Yes ☐ No ☐

If yes, indicate number: Full-term births_____ Pre-term births_____

Miscarriage/elective abortions_____ Living children_____

Family History:

Have any of your family members been diagnosed with breast, ovarian, tubal or peritoneal cancer? Yes ☐ No ☐