Gettysburg College Student Health Service **Health History**

All Information is Confidential

	/ /		/ /
Patient Name	Birth Date	Age	Today's Date

Reason for visit: _____

ALLERGIES: (medication, latex, environmental, food)

_____

PERSONAL AND FAMILY MEDICAL HEALTH HISTORY

Check the appropriate column if you or a family member has ever had any of the following:

Condition	Self	Family (if yes, who)	Comments
Anemia			
Asthma/Lung Problems			
Bleeding or clotting problems			
Brain/neurological disease			
Breast cancer or disease			
Cancer (type?)			
Depression/anxiety			
Diabetes			
Eating Disorder (type?)			
Elevated cholesterol			
Gallbladder disease			
Heart problems/murmurs			
High blood pressure			
Kidney disease			
Migraine/severe headaches			
Seizures			
Thyroid problems			
Varicose veins			
Other medical problems			

Weight gain /loss of 10 lbs. or more in past year? Yes □ No □ If **Yes,** explain: _____

_____

Current Medication/Supplements/Vitamins & Dosage: (including birth control):_____

_____

Have You Ever Been Hospitalized or Had Surgery? Yes □ No □

Date	Diagnosis/Treatment
_____/_____	_____
_____/_____	_____

Do you use any of the following? (check all that apply)

None □ Nicotine □ Alcohol □ Recreational Drugs □

Have you ever had or been exposed to the following? (if yes, check all that apply)

Yeast infection □
Herpes □
Chlamydia □
Gonorrhea □
Genital Warts □
Bacterial Vaginosis □
Trichomoniasis □
Pelvic Inflammatory Disease (PID) □
Frequent Urinary Infections □
Unusual Vaginal Discharge □
History of abnormal PAP smear □

Comments: _____

Name_____

Date last HIV test: _____/_____ Result: negative □ positive □ **HPV vaccine:** Yes □ No □
(If tested) mo. yr. If yes, date completed _____/_____

GYNECOLOGICAL/ MENSTRUAL HISTORY

Age of first period ___ FIRST day of last period ___/___/____

Avg. # days of menstrual flow ___ Avg. # days between periods ___

Do you have problems with periods? Yes □ No □ If **Yes**, explain: _____

Do you suffer from PMS (i.e. nervousness, irritability, depression)? Yes __ No __

Date of last Pap test ___/___/____ Date of last pelvic exam ___/___/____

Do you perform self breast exams? Yes □ No □

Comments: _____

CONTRACEPTIVE HISTORY

Current Contraceptive Methods:
None □ Condoms □ BC Pills □ Nuva Ring □ Patch □ Depo Provera □ Other: _____

How long have you been using this method? _____ Problems? _____

List methods used in past: _____ Problems? _____

Comments: _____

SEXUAL HISTORY - Gender Identity M □ F □ FTM □ MTF □ Additional_____

Are you sexually active? Yes □ No □ If yes, sexual orientation: male □ female □ both □ questioning □

Type(s) of sexual contact: vaginal □ oral □ anal □ Age of first vaginal intercourse: _____yrs.

Number of lifetime sexual partners: ___ # of current partners: ___ # partners in past: 3 mos. ___ 12 mos. ___

Length of current sexual relationship: ____ Condom use to reduce the risk of STD's? Yes □ No □
If **No**, explain: _____

Pain/bleeding with sexual activity? Yes □ No □

Ever a victim of physical/sexual abuse/assault/rape? Yes □ No □

Have you ever been pregnant? Yes □ No □ If **Yes**:

Dates	Outcome	Problems
___/____	_____	_____
___/____	_____	_____

IMPORTANT: *Click on the **Gynecologial Health examination** webpage, located on the Gettysburg College Health Services website, to review pertinent women's health information prior to your appointment. If you are interested in starting or renewing birth control, click on **Birth Control Options** webpage prior to your appointment and review birth control information.* ***Remember to bring this COMPLETED form with you to your appointment.***

Student signature: _____ **Date:** _____/_____/_____
Reviewed by: _____ **Date:** _____/_____/_____