THE FLORIDA STATE UNIVERSITY
UNIVERSITY HEALTH SERVICES
HEALTH & WELLNESS CENTER

FSU Health
Services ID#:_____

Women's Clinic Annual Exam

Date_____

Name_____ **Date of Birth**_____

This information is asked in order to provide you the best care possible. It is strictly confidential. If you are uncomfortable answering any question below, you may leave it blank.

Yes **No** Have you ever had surgery or been hospitalized overnight (If yes, please describe)? _____

_____

_____

Please circle if you have ever had any the following.

Blood Clotting Disorder	Diabetes	High Blood Pressure	Migraine Headaches	Seizures
Heart Disease	Cancer	Hepatitis	Thyroid Disease	Depression

Other_____

Yes **No** Have your parents, brothers or sisters had any of the above (If yes, please explain)? _____

_____

_____

How old were you when you started your menstrual periods? _____

How many days in between periods? _____ How many days does your period last? _____

Are your periods: ☐ Light ☐ Moderate ☐ Heavy

Are you or have you ever been sexually active with: ☐ Men ☐ Women ☐ Men & Women ☐ Never Sexually Active

Types of sexual contact: ☐ None ☐ Oral ☐ Vaginal ☐ Rectal

Yes **No** Have you ever been forced to have sexual contact against your will?

Yes **No** Have you ever been in a relationship where you were physically hurt or threatened?

Yes **No** Have you ever had a sexually transmitted infection? If yes, please explain_____

_____

Yes **No** Have you ever been pregnant? If yes, number of: Full Term _____ Miscarriage _____ Abortion _____

Yes **No** Have you had the HPV vaccine (Gardasil, Gardasil 9, or Cervarix) that helps prevent Cervical Cancer and Genital Warts?

When was your last pap test? _____

Yes **No** Have you ever had an abnormal pap or treatment of your cervix?

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Patient Signature_____ Clinician Signature_____

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