TCU STUDENT AFFAIRS | Brown-Lupton Health Center

Date:_____ TCU ID#_____

GYNECOLOGICAL HISTORY

_____ _____ _____ _____

Last Name First Name Initial Date of Birth Age

*Local Address/Dorm+Rm#*_____

Cell Phone (____) ____-_____ May we leave a message on this phone? **Y N**

e-mail address: _____@tcu.edu May we email you? **Y N**

Marital Status: _____Never Married _____ Married _____ Divorced

What is the reason for today's visit?

PERSONAL MEDICAL HISTORY

Check if you have had any of the following the last 90 days.

_____ High blood pressure
_____ Blood clots in legs or lungs
_____ Chest pain/ difficulty breathing
_____ Heart murmur/problem
_____ Stroke
_____ Blurred or double vision
_____ Severe headaches
_____ High cholesterol
_____ Liver problems/hepatitis
_____ Mononucleosis
_____ Abdominal/pelvic pain
_____ Unusual vaginal discharge or bleeding
_____ Breast discharge/lump
_____ Abnormal Pap smear
_____ Uterine tumor or fibroid
_____ Emotional problems/depression
_____ Major illness/surgery
_____ Stomach/bowel problems
_____ Redness/pain in leg
_____ Varicose veins
_____ Epilepsy/seizure
_____ Anemia
_____ Sickle Cell trait/disease
_____ Diabetes
_____ Birth defects
_____ Measles/measles vaccine
_____ Cancer
_____ Gallbladder problems
_____ Kidney/bladder disease

OTHER PERSONAL HISTORY – CIRCLE ANSWER

Are you adopted? **YES NO**

Any allergies to medication or metals? **YES NO** If yes, list:_____

Is there a history of breast cancer in your family? Yes No

Do you smoke cigarettes? **YES NO** If yes, how many per day?_____

Do you drink alcohol? **YES NO** If yes, how much per day?_____

Do you use drugs? **YES NO** If yes, how often and type?_____

Are you presently under doctor's care for any condition? **YES NO**

List any medications, including any type of birth control, you have taken in the last 60 days: (include Botanical and herbal meds &

vitamins):_____

_____

Date of Last Pap smear_____ Have you ever had an abnormal Pap Smear? YES NO

 TCU ID___________________

MENSTRUAL HISTORY

First day of last menstrual period__________________

Was it normal? **Yes** **No** If no, in what way was it abnormal:________________________________

Age period began___________ Period lasts _____ days

Are your periods: Light ___ Moderate ____ Heavy ____. Do you have regular periods each month? **YES** **NO**

Do you have severe menstrual cramps each month? **YES** **NO**

SEXUAL HISTORY

Have you ever had sexual intercourse? **YES** **NO**
Sexual Orientation (Optional) ___ Homosexual _____ Heterosexual _____ Bisexual

If you have never had sexual intercourse – skip to end for signature.

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Age at first intercourse ______ Are you currently having sex? **YES** **NO**
When was the last time you had sex? (date/time)______________________________________
How many sexual partners have you had?___________
Have you had more than one sexual partner in the last three months? **YES** **NO**
Have you ever had a Sexually Transmitted Disease? **YES** **NO**
Do you wish to be tested for:

Gonorrhea **YES** **NO**
Syphilis **YES** **NO**
Chlamydia **YES** **NO**

Do you bleed during or after intercourse? YES NO Is intercourse painful? YES NO

CONTRACEPTIVE HISTORY

Do you think you are pregnant **YES** **NO**
What method of contraception are you using now?__________________________________
Check methods you have EVER used:

_____ pills
_____ Norplant
_____ Foam/condom
_____ Natural Family Planning
_____ Depo Provera
_____ Lunelle
_____ IUD
_____ Withdrawal
_____ Rhythm
_____ Diaphragm
_____ Sponge
____Ortho Evra Patches
____Nuva Ring

Problems with any method?____

Method wanted NOW ____

PREGNANCY HISTORY

Total number of Pregnancies_______

_____Live births
_____Induced abortions
____ Premature births
____ Death of child in first year
_____Still births
_____Tubal/Ectopic
_____Living children now
_____Children placed in adoption
_____Miscarriages
_____Caesarean sections
_____Children with birth defects

CONSENT TO TREAT

I, ______________________voluntarily consent to receive medical and health care services provided by the TCU Health Center physicians, employees, and such associates, assistants, and other healthcare providers, as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand that this consent to treatment will be valid and remain in effect as long as I receive services from the TCU Health Center or unless this consent is revoked by me in writing.

Signature: **Date:**
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