

University of Texas @ San Antonio

UTSA Student Health Service
6900 N. Loop 1604 West, RWC 1.500
PH: (210) 458-4142 FAX: (210) 458-4151
San Antonio, TX 78249-0684

University Health and Counseling Services
501 West Durango Blvd, BV 1.308
PH: (210) 458-2930 FAX: (210) 458-2935
San Antonio, Texas 78207-4415

Women's Health Clinic Intake Information

NAME: _____ BANNER ID: _____ DATE _____
LOCAL ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE: _____ D.O.B.: ____/____/____ AGE: _____

It is the philosophy of the staff of the UTSA Student Health Services to provide you with the best care possible. To accomplish this, it is important for us to review significant health issues that might impact your health. This history form is a confidential document that will be kept in your medical record in Health Services. No information may be released without your written consent, unless required by law.

Menstrual History

1. Age when you had your first period? _____ Are your periods regular? Yes No
2. Periods come every _____ days. Periods last for _____ days.
3. When did your last period begin? _____
4. Do you have cramping? Yes No Do you take medication for cramps? Yes No
5. Have you ever had excessive menstrual bleeding? Yes No Not sure
6. Do you have significant problems with premenstrual syndrome (PMS)? Yes No
If yes, please indicate symptoms: _____
7. Have you had unprotected sex with a male partner since your last menstrual period? Yes No
8. Do you think you might be pregnant? Yes No Not sure

Gynecological Health

1. Have you ever had a pelvic examination before? Yes No
2. Date of your last pap smear or pelvic exam? _____ Was it normal? Yes No Don't know
3. Do you check your breasts monthly for lumps or discharge? Yes No
4. Have you ever had a mammogram? Yes No If yes, where and when? _____
5. Did your mother take the hormone diethylstilbestrol (DES) while pregnant with you? Yes No Don't know
6. Have you ever been pregnant? Yes No If yes, when? _____
7. How many live births? _____ How many miscarriages? _____ How many terminations? _____
8. If pregnant recently, are you now breast-feeding? Yes No
9. Have you had any pregnancy complications? Yes No If yes, explain: _____
10. Have you ever had:
Abnormal pap smear Yes No Pain or bleeding with intercourse Yes No
Breast lumps or discharge Yes No Vaginal infections or abnormal discharge Yes No
Gynecological (pelvic) surgery Yes No If yes, please describe: _____
Gynecological problems without surgery
(e.g., cyst, fibroid) Yes No _____

Sexual History

Answers to the following questions help your clinician provide appropriate care for you. Leave questions blank if you are uncomfortable answering them. Please feel free to discuss any concerns with your clinician.

1. Have you ever been sexually active (i.e., genital contact with another person)? Yes No
2. Are you currently sexually active? Yes No
3. Have your partners been Men Women Both
4. Do you have any concerns regarding sexual functioning or orgasm? Yes No
5. Do you have questions regarding:
Sexual orientation? Yes No
Gender identity? Yes No

6. Are you comfortable with your own sexuality? Yes No
7. Have you ever had any of the following STDs (sexually transmitted diseases):
- | | | | |
|-----------------------------|--|-----------------------------------|--|
| Chlamydia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Syphilis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Genital warts / HPV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gonorrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, dates and comments: _____ | |
| Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | |
| Pelvic inflammatory disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
8. If you have a current partner, does he or she display any symptoms of a STD? Yes No Not sure
9. Did you use safer sex practices (condom, dental dam, etc) during your last sexual activity? Yes No
10. Have you practiced safer sex with your current partner Always Sometimes Never
with past partners Always Sometimes Never
11. What are you using to prevent pregnancy? _____
Are you in need of a birth control method? Yes No
12. If you are using or have used oral contraceptives, have you had any associated complications or side effects, such as:
- | | | | |
|-------------------------------------|--|--|--|
| Headaches that started or got worse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice (yellowing of the skin or eyes) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (please explain): | _____ |
13. Do you have questions about birth control methods? Yes No Not applicable

PRIVACY NOTICE

With a few exceptions, you are entitled to be informed about the information U.T.San Antonio collects about you. Under section 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review this information. Under Section 559.004 of the Texas Government Code, you are entitled to have U.T.San Antonio correct information about you that is held by us and that is incorrect, in accordance with the procedures set forth in the University of Texas System Business Procedure Memorandum 32. The information the U.T. San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq of the Texas Government Code) and rules. Different types of information are kept for different periods of time.

General Health History (to be reviewed with nurse):

1. Additional family medical history (parent, sibling, grandparent):

- | | | | |
|-------------------------|--|--|--|
| Blood clotting disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Early heart attack | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hypercholesterolemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | (Mother prior to the age of 65
Father prior to the age of 55) | |

2. Additional Personal History

- | | | | |
|----------------------------------|--|--|--|
| Blood in stool | <input type="checkbox"/> Yes <input type="checkbox"/> No | Planning major surgery/immobilization | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest pain/pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rapid/irregular heartbeat | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CAD/MI | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent weight gain/loss (over 10 lbs) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Elevated level of HDL/TGL/Lipids | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Enlarged glands/lymph nodes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle cell disease/trait | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glasses/contacts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke/CVA/cerebral hemorrhage | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hirsutism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thrombophlebitis/Pulmonary embolism | |
| Kidney disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | /blood clotting disorder/vein problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver/gallbladder disease/cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Urinary frequency/excessive quantity | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| New/changing moles | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Nursing Notes:
