



# Student Health Center

University of Missouri Health

Student Health Center  
University of Missouri  
1020 Hitt Street  
Columbia, MO 65212

Name

All information is CONFIDENTIAL

## REPRODUCTIVE HEALTH PROFILE

Age \_\_\_\_\_ Relationship status: \_\_\_\_\_

### Menstrual History

Age periods began \_\_\_\_\_ First day of your last menstrual period \_\_\_\_\_

Are your periods regular?  Yes  No

How many days between the first day of one period and the first day of the next period? \_\_\_\_\_ days

How many days does your period last? \_\_\_\_\_ days

Menstrual bleeding  light  moderate  heavy

Menstrual cramps?  none  mild  moderate  severe

Other symptoms with your period? \_\_\_\_\_

### Pap Smear History

Date of last pap \_\_\_\_\_

Ever have an abnormal pap?  Yes  No If yes, when? \_\_\_\_\_

### Sexual Health History

Have you ever had sexual contact?  Yes  No Are you currently having sexual contact?  Yes  No

How long have you been sexually active with current partner? \_\_\_\_\_

Number of sexual partners in the last 3 mos \_\_\_\_\_ 1 year \_\_\_\_\_

Current or previous partner(s) are  Male  Female  Both  Not Applicable

Ever engaged in — Oral intercourse:  Yes  No Vaginal intercourse:  Yes  No Anal intercourse:  Yes  No

Have you ever been tested for sexually transmitted infections (STIs)?  Yes  No

If yes, was the testing done in the past year?  Yes  No

Have you ever been diagnosed with a STI?  Yes  No

If yes, what type(s)?  Gonorrhea  Genital Warts/HPV  Chlamydia  Syphilis  Herpes  HIV

What type of barrier methods do you currently use:

None  Condom  Condom and Spermicide  Dental dam

If you currently practice birth control, which method(s) do you use? \_\_\_\_\_

Have you ever been pregnant?  Yes  No If yes, when? \_\_\_\_\_

Are you concerned that you may be pregnant now?  Yes  No

Have you ever heard of the Emergency Contraceptive Pill (morning after pill)?  Yes  No

Have you ever been sexually assaulted or abused?  Yes  No

**Review of present health symptoms** (Check only those that you're experiencing now)

- Unusual vaginal odor, discharge, itching or burning.
- Genital sores or growths.
- Urinary frequency, burning and / or urgency.
- Pelvic pain
- Concern about feel, appearance, or changes in breasts
- Other gynecological symptoms \_\_\_\_\_
- Irregular or excessive menstrual bleeding
- Pain during intercourse
- Bleeding after intercourse
- Nipple discharge

**Immunization History**

When was your last tetanus shot? \_\_\_\_\_

Have you had the HPV vaccine?  Yes  No If not, are you interested in receiving it?  Yes  No

**Habits/Risk Behavior**

Do you exercise regularly?  Yes  No Number of times/week? \_\_\_\_\_ Duration? \_\_\_\_\_

How many servings of dairy products (milk, cheese, yogurt, ice cream) do you eat daily? \_\_\_\_\_

Have you had your cholesterol checked in the last 5 years?  Yes  No

Are you afraid of being physically hurt by your partner or someone else?  Yes  No

**Past Health History**

Have you or your parents had any of the following conditions? If you are adopted, please check here.

Condition	You	Mother	Father
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots in legs, lungs or phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gynecological problems including cancers (what type?) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack (before age 60)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease or Trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>