



Student Health Center

University of Missouri Health System

Student Health Center
University of Missouri
1020 Hitt Street
Columbia, MO 65201

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"/>