ERAU WELLNESS CENTER

MEDICAL HISTORY

NAME:_____ **PHONE#:**_____

DOB:_____ **STUDENT ID#**_____

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. Do you have significant problems with premenstrual syndrome (PMS) YES NO

If yes, please indicate symptoms:_____

6. Do you have any problems with vaginal discharge, odor or itching? YES NO

If yes, please describe_____

_____

7. Are you a smoker? YES NO
8. Do you have migraines? YES NO
9. Do you have any history of breast problems? YES NO
10. Are you sexually active? YES NO
11. If yes, have you ever had pain or bleeding with intercourse? YES NO
12. Have you ever been treated for a STD (sexually transmitted disease)? YES NO

If yes, please explain_____

13. Do you use condoms? YES NO
14. Are you aware that the Wellness Center provides free condoms? YES NO
15. Are you using any birth control medications? YES NO

If yes, which one_____ and do you need a refill? YES NO

16. Are you having any other medical problems at this time? YES NO

If yes, please explain_____

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