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

Date of Birth ____________ 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	❑	❑	❑
Autoimmune Disorder	❑	❑	❑
Blood Clots in legs, lungs or phlebitis	❑	❑	❑
Breast Cancer	❑	❑	❑
Clotting Disorder	❑	❑	❑
Depression	❑	❑	❑
Diabetes	❑	❑	❑
Gynecological problems including cancers (what type?) ______________________	❑	❑	❑
Heart Attack (before age 60)	❑	❑	❑
High Blood Pressure	❑	❑	❑
High Cholesterol	❑	❑	❑
Liver Disease	❑	❑	❑
Migraine headaches	❑	❑	❑
Osteoporosis	❑	❑	❑
Seizure Disorder	❑	❑	❑
Sickle Cell Disease or Trait	❑	❑	❑
Stroke	❑	❑	❑