Student Health Center
University of Missouri Health System

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
- ☐ Irregular or excessive menstrual bleeding
- ☐ Pain during intercourse
- ☐ Bleeding after intercourse
- ☐ Nipple discharge
- ☐ Other gynecological symptoms _____

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	☐	☐	☐