Truman State University
Student Health Center

Date_____
E-mail_____

Name_____ Age_____ Telephone number_____
Address to mail results_____ ☐ I prefer to be e-mailed
Your year in school_____ Allergies (including metals)_____
Medical care and medications in the past year_____
Your private health care provider_____

On a typical day, how many servings do you eat…	
Fruits	
Nuts/beans	
Breads/cereals	
Eggs/meats	
Milk/dairy products	
Vegetables	
Coffee/tea/sodas	

In a typical week, how often do you…	
Exercise	
Smoke cigarettes (number of cigarettes)	
Drink alcohol (number of drinks)*	
Use street drugs*	

*Do you (or a friend) have concerns about your drug/alcohol use? Yes ☐ No ☐
Have you completed the Gardasil vaccine series? Yes ☐ No ☐
** If No, have you started the Gardasil vaccine series? Yes ☐ No ☐

	Please indicate *Yes, No* or *Unsure (?)* in the column to the right.	Yes – No - ?	Staff Comments
Family History	Stroke or heart attack before age 50		
	High blood pressure		
	Breast or uterine cancer		
	Diabetes		
	High cholesterol		
	Genetic problems/disorders		
	Mother or sister pregnant before age 18		
Review of Systems	Frequent or severe headaches		
	Seizures/fainting/neurological disorders		
	Emotional problems/depression/eating disorders		
	Vision problems		
	Chest pain/difficulty breathing/asthma		
	Heart problems/murmurs/high blood pressure		
	High cholesterol		
	Blood clots in veins/varicose veins		
	Breast disease/lump/nipple discharge		
	Stomach/Intestinal problems		
	Gall bladder or liver disease (hepatitis/mono)		
	Kidney/bladder problems or infections		
GYN	Frequent vaginal infections/itching/burning/odor/discharge		
	Vaginal sores/bumps/rash		
	Fever or chills		

	Lower abdominal pain or pressure		
	Pain/bleeding with intercourse		
	Sexually transmitted infection. Please list:		
	PID/infection of the uterus, tubes, ovaries		
	Uterine/ovarian growths/fibroids/cysts		
	Pap smear. If yes, list date of most recent pap smear:_____		
	Abnormal pap smear		
	Have you ever been pregnant?		
	Have you ever had a miscarriage/stillbirth?		
	Have you ever had an induced abortion?		
Sexual History	Are you currently sexually active? Your age at first intercourse:_____		
	Have you had more than one sex partner in the past three months?		
	Has your partner(s) been treated for an STI or have STI symptoms?		
	Are you or have you been sexually or physically mistreated?		
	Do you have any questions about STI's/HIV infection/AIDS		

Sexual History	How many sex partners have you had in the past year? _____	**Menstrual Hx**	First day of last normal period: _____
	Partners (previous or current): Men_☐_ Women_☐_ Both_☐_		How many days do you bleed? _____
	Have you had the following types of sex: Oral _☐_ Vaginal_☐_ Anal _☐_		How often do you have periods? (example: 28 days): _____
	Do you use condoms? Never _☐_ Some _☐_ Regularly _☐_		Is your bleeding: Light_☐_ Medium_☐_ Heavy_☐_ Bleeding varies_☐_
	Are you currently using a method of birth control? Yes _☐_ No _☐_		Unusual or missed periods in the past year? Yes _☐_ No _☐_
	If yes, list current method: _____		Severe PMS or menstrual cramps? Yes _☐_ No _☐_
	Describe any problems with current method: _____		Do you think you are pregnant now? Yes _☐_ No _☐_

BC Hx	Other methods of birth control ever used by you or your partner? Oral (pill)_☐_ Condom_☐_ IUD_☐_ Withdrawal_☐_ Depo-Provera (shot)_☐_ Rhythm/NFP_☐_ Norplant_☐_ Foam/cream/suppository/film_☐_ Self sterile _☐_ _☐_Partner sterile _☐_Other_____
	Problems with any of these methods? Please list:
	Which method do you want to use now? Please list:

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of patient: _____ Date: _____

Signature of provider: _____ Date: _____