

**SEXUAL HEALTH HISTORY**  
**PRINCETON UNIVERSITY HEALTH SERVICES**

Social Security # \_\_\_\_\_ Today's date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ Phone number \_\_\_\_\_

E-mail: \_\_\_\_\_ OK to e-mail results  yes  No

Married  Single  Partner  Spouse's/Partner's name (optional) \_\_\_\_\_

**STATUS:** (circle) '08, '09, '10, '11 G, G-Spouse/Partner, SEM, SEM-Spouse/Partner Visiting Student Staff

**Menstrual History:**

Age periods started: \_\_\_\_\_  
Length of cycle (e.g 28, 30 days) \_\_\_\_\_  
Days of flow: \_\_\_\_\_  
Number of pads/tampons (heaviest days): \_\_\_\_\_  
Menstrual difficulties (cramps, spotting, irregular periods, missed periods, PMS): \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_  
Normal  yes  no

**Sexual History:**

Are you sexually active?:  Yes  No  
Do you have sex with:  Men  Women  Both  
Age of first sexual encounter? : \_\_\_\_\_  
How many partners have you had?: \_\_\_\_\_  
How long with your new partner?: \_\_\_\_\_  
Have you ever experienced unwanted sexual contact?:  
 Yes  No  
Do you have any pain or bleeding with intercourse?:  
 Yes  No  
Do you have any other concerns about sexuality?:  
 Yes  No

**Medical History**

*(Check only if positive and specify in space below)*

- |  |  |
|--|--|
| <input type="checkbox"/> Heart problem             | <input type="checkbox"/> Thyroid problems          |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> Headaches (migraines)     | <input type="checkbox"/> Diabetes                  |
| <input type="checkbox"/> Mental depression         | <input type="checkbox"/> Hepatitis, gallbladder    |
| <input type="checkbox"/> Asthma, lung problems     | <input type="checkbox"/> Urinary tract infection   |
| <input type="checkbox"/> Thrombophlebitis          | <input type="checkbox"/> Sickle cell trait/disease |
| <input type="checkbox"/> Other significant illness | <input type="checkbox"/> Eating concerns           |
| <input type="checkbox"/> Alcohol/drug concerns     |  |
- \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medication? (specify): \_\_\_\_\_

Any surgeries or hospitalizations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Gynecological History:**

**Previous Pap tests**

Date of last pap test: \_\_\_\_\_ Results: \_\_\_\_\_

Have you ever had an abnormal Pap test?  Yes  No

If yes, please specify: \_\_\_\_\_

**Birth Control History:**

Are you currently using a method of birth control?  Yes  No If yes, specify \_\_\_\_\_

Do you use condoms?  Yes  No

**Sexually Transmitted Infections**

Have you ever been diagnosed with a sexually transmitted infection (STI)?:

Yes  No If yes, Specify: \_\_\_\_\_

**Breast Problems**

Any history of breast disease?  Yes  No

**Other gynecological history**

Have you had recurrent, chronic, or persistent vaginal infections?

Yes  No If yes, specify: \_\_\_\_\_

Have you ever had gynecologic surgery?  Yes  No Specify: \_\_\_\_\_

Did you mother take DES while she was pregnant with you?  Yes  No

**Obstetrical History:**

Have you ever been pregnant?  Yes  No If yes, how many pregnancies have you had? \_\_\_\_\_

Any births?  Yes  No. If yes how many: \_\_\_\_\_

Any miscarriages?  Yes  No

Any terminations?  Yes  No

**Health Habits:**

Do you smoke cigarettes?  Yes  No If yes, how many do you smoke per day: \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No

If yes, how many per week: \_\_\_\_\_

Do you take any over-the-counter medication on a regular basis?  Yes  No If yes, specify \_\_\_\_\_

Do you take any prescription medication on a regular basis?

Yes  No. If yes, please specify \_\_\_\_\_

Do you use any illegal substances?  Yes  No, If yes, specify \_\_\_\_\_  
How often? \_\_\_\_\_

**Family History**

*(check only if positive and specify in space below)*

Cancer  Diabetes  Strokes  High blood pressure

Heart disease  Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_