Date: _____ Name: _____

Supplemental Female History Form

Reason for today's visit:

Please check any **symptoms** you are having today and indicate **how long** you have had them:	
❑ Partner diagnosed with an STD	
❑ Burning with urination	
❑ Genital itching	
❑ Change in vaginal discharge	
❑ Blisters or sores	
❑ Rash	
❑ Bumps, warts	
❑ Other:	

General Family Planning / Health Information:	
When was the **first day** of your last menstrual period?	
What is your current birth control method?	
Would you like to become pregnant in the next year?	❑ Yes ❑ No ❑ Don't know
Date of last child's delivery:	
Are you currently breastfeeding?	❑ Yes ❑ No
Have you had a new partner since your last visit?	❑ Yes ❑ No
Has your partner had a new partner since your last visit?	❑ Yes ❑ No ❑ Don't know
Do you use condoms for STI/STD protection?	❑ Yes ❑ No ❑ Sometimes
When did you last have **unprotected** (no condom) sex?	
What are your sexual practices (current and past)? Check all that applies:	❑ Vaginal ❑ Oral ❑ Anal
Are your sex partners: (check all that applies)	❑ Males ❑ Females ❑ Other:
When was your last HIV test?	

Do you have any health problems? ❑ Yes ❑ No If yes, please list: _____
List medications/supplements you are <u>currently taking</u>: ❑ None
List any medication/substance <u>allergies</u> you have: ❑ None

Has anyone ever emotionally, physically, sexually, or verbally abused you?	❑ Yes ❑ No If Yes, have you had counseling? ❑ Yes ❑ No
Are you being pressured to have sex when it is not your choice?	❑ Yes ❑ No
Does anyone try to prevent you from leaving your job or residence?	❑ Yes ❑ No
Do you have control over your own identification documents?	❑ Yes ❑ No
If you have a partner, do you feel safe with this person?	❑ Yes ❑ No ❑ I do not have a partner
If you are under 18 years of age, do you have a trusted adult to turn to for support?	❑ Yes ❑ No

Current living situation: ❑ Home ❑ Homeless ❑ Sober Living Environment ❑ Other:
What confidential telephone number can we use to call you? _____

Client Label Here