# IUPUI STUDENT HEALTH SERVICES

PAP EXAM QUESTIONNAIRE: Please circle or fill in the blank to complete the information.

Name: ______________________________ Date of Birth: ____________________

Age of onset of menses: ________________

# of days between 1st day of each cycle: ______

First day of last cycle: _____/______/_______

Have you ever used birth control? Yes No

If yes: what type? Pills Patch IUD Shots

Have you had problems with BC? Yes No

Are you currently sexually active? Yes No

Are you now having vaginal itching? Yes No

Is there a change in vaginal discharge? Yes No

Are you now having vaginal irritation? Yes No

# times/year you check your breasts? ________

Do you smoke cigarettes? Yes No

If yes, how many packs/day? ____________

At what age did you begin? ____________

Are you: overweight underweight normal

PAST SEXUAL HISTORY

Have you ever had an STD? Yes No

If yes, which one(s)? ______________________

Have you ever been pregnant? Yes No

How many times? ______ #deliveries ________

Have you ever had a pap smear? Yes No

When? ____/____Were results normal? Yes No

Have you ever had sex? Oral Yes No

Vaginal Yes No

Rectal Yes No

If yes to sex: How old were you? _____________

How many partners have you had? _____________

PAST MEDICAL HISTORY

Do you have or have you ever had:

| | | |
|---|---|---|
| Anemia | Yes | No |
| Asthma | Yes | No |
| Blood clots | Yes | No |
| Breast lump | Yes | No |
| Depression | Yes | No |
| Diabetes | Yes | No |
| Epilepsy | Yes | No |
| Eye problems-besides glasses | Yes | No |
| Inflammation of leg veins | Yes | No |
| Kidney disease | Yes | No |
| Liver disease or jaundice | Yes | No |
| Migraine or severe headaches | Yes | No |
| Thyroid problems | Yes | No |

Other: ______________________________________

FAMILY HISTORY;Is there a family history of:

| | | |
|---|---|---|
| Blood clots | Yes | No |
| Cancer | Yes | No |
| Diabetes | Yes | No |
| Heart problems | Yes | No |
| High blood pressure | Yes | No |
| Strokes | Yes | No |

MEDICAL INFORMATION:

Weight: __________ Height: _______ B/P ____/_____

Weight gain ____ #/yr Loss: ____#/yr Voluntary? Yes No

Medications: ______________________________________

Allergies: ________________________________________

PHYSICAL EXAMINATION

Breast:

Abdomen:

Ext genitalia

Vagina

Cervix:

Uterus:

Adnexa:

Rectal:

PROVIDERS ORDERS: RESULTS:

( ) Pap:_____________________________________

( ) Chlamydia/GC: ____________________________

( ) Wet Mount: _______________________________

COMMENTS: _________________________________

____________________________________________

____________________________________________

PLAN: ______________________________________

____________________________________________

RX: BC #MONTHS .

RTC IN ________________MONTHS ___________

MD/NP Signature____________________________

Date: ________ Nurse: ________________________

Comments on any of the above: ______________________________________________

______________________________________________________________________

rev: 03/04