



Today's Date: _____ DOB: _____ Age: _____

Name: _____ Allergies: _____

Reason for Visit: _____

Vaginal Discharge: yellow green pink white brown /
clumpy watery mucous creamy

Vaginal Odor: fishy sour metallic

Vaginal Itching: Yes No

For how long? _____

Urinary Symptoms: painful frequent urge pressure urinating small amounts
lower back pain fever chills

For how long? _____

MENSTRUAL CYCLE	SEXUAL HISTORY
<p>Date last period started: Normal Not Normal</p> <p>Vaginal bleeding between menstrual cycles: Yes No</p> <p>Do you have vaginal bleeding after sex? Yes No</p> <hr/> <p>PREGNANCY HISTORY</p> <p>Never Pregnant</p> <p>Are you currently pregnant? Yes No</p> <hr/> <p>REPRODUCTIVE LIFE PLAN</p> <p>Are you planning a pregnancy in the next year? Yes No</p> <p>What would you do if you got pregnant in the next year?</p> <hr/> <p>BIRTH CONTROL</p> <p>Are you currently on a birth control method? Yes No</p> <p>If yes, which method(s)</p> <p>Would you be interested in a birth control method? Yes No</p>	<p>Age at first intercourse:</p> <p>Number of sexual partners in the last 6 months:</p> <p>Last time you had sex: Protected Unprotected</p> <p>Have you ever had: Vaginal Sex Anal Sex Oral Sex</p> <p>Do you have sex with: Men Women Both Other Gender None</p> <p>Have you ever been forced to have sex? Yes No</p> <hr/> <p>HISTORY OF SEXUAL TRANSMITTED INFECTION</p> <p>None</p> <p>Chlamydia</p> <p>Genital Warts</p> <p>Syphilis</p> <p>PID</p> <p>Other:</p> <p>Gonorrhea</p> <p>Herpes</p> <p>HIV/AIDS</p> <p>Trichomoniasis</p>