

**COLLEGE OF WILLIAM AND MARY
STUDENT HEALTH CENTER
GYN/GU Check List--Female**

Name: _____ ID# _____ Date _____

Telephone # _____ Age _____ Drug allergies _____

Current Medications (include herbals and vitamins) _____

Date of last Pap _____ Results _____ History of Abnormal pap? _____

Do you have Diabetes? _____ Hepatitis B series completed? _____

Contraception used _____ Number of times condom used in last 10 encounters _____

First day of last period _____ History of unprotected intercourse? _____ Date _____

History of sexually transmitted infection (STI)? _____ If yes: Type/ Date/Treatment _____

Have you ever had an HIV Test? _____ date/result _____

Have you had sex with men _____ women _____ both _____

Have any of your partners been bisexual _____ used drugs _____ had a history of STIs _____

Number of partners in the past year _____

Symptoms: Abdominal Pain Back Pain Vaginal Discharge: Color _____ Odor? _____

Itching/sores/bumps on/in: mouth labia vagina rectal area Length of time present _____

Known exposure to any STI /type _____

Please be aware we are required to report certain infections to the Health Dept. **if** testing is **positive**.

Do not write below this line (for Health Center use only)

S: _____

O: T _____ B/P _____ P _____ R _____

Labia: _____

Vagina: _____

Cervix: _____

Rectum: _____

A: _____

P: Tests Done: KOH Wet prep HCG U/A Acetic acid **Pap Chlamydia GC HIV RPR HSV**

Culture Hep. B serology other _____

Treatment: _____

Patient instruction: Safer sex Hep. B HIV testing

Positive: **Chlamydia GC HIV RPR** reported to PHD _____ (initials) _____ (date)

Nurse _____ Provider MD NP PA