Suburban Women's Specialists, LLC

NAME: _____ DOB: _____

GYN HISTORY Date of last menstrual period: _____

Age of first period _____ How long is your period? _____ How often do you have period? _____

How would you describe your periods? □ Light □ Mild □ Heavy Do you have pain with periods? □ Yes □ No

Prior history of STD Infection? □ No □ Yes _____

Prior history of Abnormal Pap Smear? □ No □Yes _____

Date of Last Pap Smear _____ Result _____

Contraceptive Method: _____

Urinary Problems: □ Urgency □ Frequency □ Pain during urination □ Loss of urine when coughing, laughing or sneezing

Menopause? □ No □ Yes (age: ____) Hormone Replacement? □ No □ Yes

Date of Last Mammogram _____ Result _____

Prior history of Abnormal Mammogram? □ No □ Yes _____

MEDICAL HISTORY

	Do YOU or have you EVER had any of the following conditions?		Does anyone in your family have any of the following conditions?	
	YES	NO	YES	NO
Bleeding Disorder				
Cancer				
Diabetes				
Heart Disorder				
Hepatitis/Infectious Disease				
High Blood Pressure				
Lung Disorder				
Musculoskeletal Disorder				
Neurological Disorder				
Psychiatric Disorder				
Stomach/Bowel Disorder				
Thyroid Disorder				

Drug Allergies: _____ Current Medications: _____

Are you a smoker? □ NO □ YES _____ packs/day Do you drink alcohol? □ NO □ YES _____ # Drinks/day

Hospitalization or Surgeries

Please list any hospitalizations, surgeries or illness/injuries (requiring a visit to the ER) - Include date/name of hospital

_____

_____

_____

_____

_____

PREGNANCY HISTORY

No.	DATE Mo/Day/Yr	WEEKS AT DELIVERY	LENGTH OF LABOR	BIRTH WEIGHT	SEX M / F	TYPE OF DELIVERY	ANESTHESIA	PLACE OF DELIVERY	PRETERM LABOR?	COMMENTS/ COMPLICATIONS
1										
2										
3										
4										
5										

_____ _____

Signature of Patient/Guardian Date