

**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

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**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