

COMPREHENSIVE MEDICAL HISTORY

Name _____ Date _____

Current Medications: _____
 Medication Allergies: _____ Reactions: _____

Medical History

Have You Had?	No	Yes	Date	Have You Had?	No	Yes	Date
Anorexia				Liver problem/disease (specify)			
Arthritis				Lung problem/disease (specify)			
Asthma				Mono			
Birth defects				Infertility			
Blood disorders/disease (specify)				History of Sexual or Physical Abuse			
Breast lump				Osteoporosis			
Cancer (specify)				Ovarian cysts/growths			
Chickenpox				Infection of uterus/tubes/ovaries			
Chlamydia				Psychiatric disorder (specify)			
Depression				Rheumatic fever			
Diabetes				Skin problems/disease (specify)			
Hard pain/cramps with periods				Stroke			
Ear problems/disease (specify)				Syphilis			
Epilepsy				Thyroid problems/disease (specify)			
Eye problem/disease (specify)				Tuberculosis			
Uterine growths/fibroids				Bladder infection			
Breast nipple discharge				Abnormal Pap smear			
Gastric ulcer				Other (specify)			
Genital warts							
Gonorrhea							
Hay fever/seasonal allergies							
Hepatitis (specify type)				Indicate whether you've had these tests and date of last one			
Do you ever miss a periods?				Pap smear			
Genital herpes				Mammogram			
Heart problem/disease (specify)				Colonoscopy			
High blood pressure				Bone density			
Kidney problem/disease (specify)				Thyroid			
Kidney infection				Cholesterol			

Surgical History

Date	List all previous hospitalizations, surgeries and procedures

Are you adopted? No Yes If yes, do you know your family history? No Yes

Family History

Has Any Blood Relative Ever Had?	No	Mat. Relative (specify)	Pat. Relative (specify)	Has Any Blood Relative Ever Had?	No	Mat. Relative (specify)	Pat. Relative (specify)
Arthritis				Goiter			
Asthma				Gout			
Birth Defect				Hay fever/allergies			
Blood disorder				Heart disease (specify)			
Breast cancer				Hepatitis (specify type)			
Cervical cancer				High blood pressure			
Ovarian cancer				Kidney disease (specify)			
Other cancer (specify)				Osteoporosis			
Birth defect				Stroke			
Diabetes				Thyroid disease			
Emphysema				Tuberculosis			
Endometriosis				Twins or Triplets			

Family Members

	Living	Health condition (poor/fair/good/excellent)	Deceased/Year/At what age
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Pregnancy History Have you ever been pregnant? **Yes No**
Please list all pregnancies

Delivery Date	Mo. Along	Vag or C-section	Complications	Living

Have you ever had a miscarriage or abortion? Yes No

Date	Wks. Along	Miscarriage	Abortion	Complications

Menstrual History

Age at first menstrual period _____
 How often do you have periods? Every _____ days
 How many days does period last? _____ days
 Is your flow (circle one) Light Moderate Heavy
 Bleeding/spotting between periods? No Yes
 Pass clots with periods? No Yes
 Current method of preventing pregnancy: Abstinence (not sexually active) None (unprotected intercourse)
 (circle all that apply) Natural Family Planning Withdrawal Condoms Foam/Gel/Suppository
 Diaphragm Depo Provera IUD Oral Contraceptives
 Tubal Sterilization Partner Vasectomy Hysterectomy

Social History

Occupation _____

Substance Use

Caffeine never _____ times/day
 Tobacco never _____ times/day
 Alcohol never _____ times/week
 Street drugs never _____ times/week

Education

Grade school _____ years
 High school _____ years
 College _____ years
 Postgraduate _____ years

Since your last annual exam . . .

Name _____

Since your last annual exam . . .

Name _____

Constitutional

Seat Belt Use Yes No
 Regular Exercise Yes No
 Recent weight gain No Yes
 Recent weight loss No Yes
 Chronic fatigue No Yes

Eyes

Eye injury No Yes
 Glaucoma No Yes
 Blurred vision No Yes
 Double vision No Yes
 Do you wear glasses/contacts No Yes

Head, Ears, Nose, Mouth, Throat

Dizziness No Yes
 Frequent sinus infections No Yes
 Ear problems No Yes
 Impaired hearing No Yes
 Frequent itchy/runny nose No Yes
 Frequent nosebleeds No Yes
 Frequent mouth sores No Yes
 Frequent sore throats No Yes
 Hoarseness No Yes

Breasts

Monthly self breast exams Yes No
 Breast tenderness No Yes
 Breast swelling No Yes
 Breast lumps No Yes
 Nipple discharge No Yes
 Currently breast feeding No Yes

Cardiovascular

Chest pain or angina No Yes
 Heart attack No Yes
 Heart murmur No Yes
 Shortness of breath with exertion No Yes
 Shortness of breath at all times No Yes
 Swelling of hands, feet or ankles No Yes
 Varicose veins No Yes
 Phlebitis (inflammation or clots in veins) No Yes

Respiratory

Difficulty breathing No Yes
 Wheezing No Yes
 Coughing up blood No Yes
 Current common "cold" symptoms No Yes
 Chronic cough No Yes
 Frequent bronchitis No Yes

Gastrointestinal

Loss of appetite No Yes
 Heartburn No Yes
 Indigestion No Yes
 Vomiting blood No Yes
 Gallbladder disease No Yes
 Cramping or pain in the abdomen No Yes
 Hemorrhoids No Yes
 Constipation No Yes
 Frequent diarrhea No Yes
 Change in bowel habits No Yes
 Painful bowel movements No Yes
 Bleeding with bowel movements No Yes
 Black or tarry stools No Yes
 Incontinent of stool No Yes

Genitourinary

Irregular menstrual periods No Yes
 Pelvic pain No yes
 Vaginal dryness No Yes
 Vaginal itching No Yes
 Vaginal odor No Yes
 History multiple sexual partners (5+) No Yes

Recent new sexual partner No Yes
 History of sexually transmitted infection No Yes
 Onset of sexual activity <17 years No Yes
 Painful intercourse No Yes
 Involuntary loss of urine No Yes
 Frequent urination No Yes
 Nighttime urination No Yes
 Burning/painful urination No Yes
 Blood in urine No Yes
 Change in urine color No Yes
 Foul smelling urine No Yes
 Pregnancy since last visit No Yes
 Chance you might be pregnant today No Yes
 First day of your last menstrual period _____

Skin

New lesions No Yes
 Changes in moles (color, shape, itching, irritation) No Yes
 Rashes No Yes
 Eczema No Yes
 Psoriasis No Yes
 Frequent infections or boils No Yes
 Jaundice (yellow skin and eyes) No Yes
 Frequent tanning/bed use No Yes

Neurological

Frequent headaches No Yes
 Current or past fainting spells No Yes
 Memory difficulties No Yes
 Balance difficulties No Yes
 Seizures No Yes
 Tremors No Yes
 Lack of coordination No Yes
 Numbness or tingling No Yes

Musculoskeletal

Any physical disabilities No Yes
 Frequent back pain No Yes
 Joint pain No Yes
 Joint stiffness No Yes
 Joint swelling No Yes

Endocrine

Hormone therapy No Yes
 Hair loss No Yes
 Facial hair growth No Yes
 Intolerant to heat and cold No Yes
 Skin overly dry No Yes
 Excessive thirst No Yes
 Excessive urination No Yes
 Hot flashes No Yes
 Night sweats No Yes

Psychiatric

Psychiatric diagnosis No Yes
 Hospitalized for psychiatric reasons No Yes
 Attempted to hurt yourself or others No Yes
 Anxiety No Yes
 Panic attacks No Yes
 Depression No Yes
 Difficulty sleeping No Yes
 Eating disorders No Yes

Hematologic/Lymphatic

Anemia No Yes
 Experience excessive bleeding No Yes
 Do you bruise easily No Yes
 Received a blood transfusion No Yes
 Any unusual swelling or lumps No Yes

Allergic/Immunologic

Seasonal allergic symptoms	No	Yes
Tetanus immunization in last 10 yrs	Yes	No
Are you sick a lot	No	Yes
History of chicken pox or immunity	Yes	No

Other

Do you have any other problems	No	Yes
Do you have any questions for us	No	Yes

Comments _____

Patient Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Employer _____ Occupation _____
Driver's License # _____ Social Security # _____
Date of Birth _____ Marital Status M S W Sep D

Spouse Name _____ Date of Birth _____
Employer _____ Occupation _____ Work Phone _____
Spouse Social Security # _____

Primary Insurance _____ Effective _____
Policy Holder _____ Relationship to You _____
Policy Holder Date of Birth _____ Policy Holder Social Security # _____
Secondary Insurance _____ Effective _____
Policy Holder _____ Relationship to You _____

Primary Care physician you have listed with your insurance carrier _____
Whom may we thank for referring you to our practice? _____

TELEPHONE NOTIFICATION CONSENT

Due to our concern for your confidentiality, we are asking that you sign a release to advise us how we may contact you.
Please select one or more options.

I give permission for office staff to call and identify themselves as calling from South Shore Women's Health Care and leave detailed information regarding my appointment schedule, test results, prescriptions or care on my answering machine:

- At Home # _____
- At Work # _____
- Cell Phone # _____
- Do not phone me. I understand I will receive all (urgent and non-urgent) notifications and reminders by mail only.

I also give permission for office staff to speak with the following individual(s):

Signed _____ Date _____

Disclosure / Agreement

Date: _____

Acct #: _____

Name: _____

Reason for Today's Visit

_____ ***Routine Preventive Exam*** (I have no medical complaint or significant problem or abnormality that I am aware of). **If my Provider recommends that I have a 3-day Hemocult (Fecal) test done and provides me with the testing kit, I understand I must return this sample within 45 days or I will be assessed a \$5.00 administrative charge for the supplies I was provided with. However, if I choose *NOT* to do this test, I will inform the Provider of my decision, and not take the testing kit with me.**

_____ ***I have a Problem/Complaint*** that I wish to have evaluated/treated by my Provider. My chief complaint is: _____

_____ My insurance plan **covers** Preventive Medical Services

_____ My insurance plan **does not cover** Preventive Medical Services.

_____ I **do not know** if my insurance plan covers Preventive Medical Services.

I understand that this office will file a claim to my insurance plan on my behalf for these services. For non-participating insurance plans (the insurance reimburses to the patient directly). We will bill your insurance company ONE time as a courtesy to you. I also understand there will be an additional charge for the collection of my Screening Pap Smear today; that is separate from the office visit charge. If my insurance carrier refuses payment for preventive visits, or deems these services as non-covered benefits, I agree to pay for these services in full.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record by my care provider. The policy of this office does not allow documented coding to be altered for the purpose of insurance reimbursement.

By my signature, I certify that I have read, understand and agree to the stipulations outlined above.

By: _____

Patient Signature (or Responsible Party for Minor)