

Put a ✓ if it applies to you

Review of Systems

Name: _____ DOB: (____/____/____)

GENITOURINARY

- | | |
|--|--|
| <input type="checkbox"/> Any abnormal pap smears, in past 3 years | <input type="checkbox"/> Vaginal odor |
| <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Burning/painful urination |
| <input type="checkbox"/> Vaginal <input type="checkbox"/> dryness <input type="checkbox"/> itching | <input type="checkbox"/> Involuntary loss of urine |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Bleeding w/ bowel movements |
| <input type="checkbox"/> Nighttime urination | <input type="checkbox"/> Black Tarry Stools |
| <input type="checkbox"/> Blood in urine | |

SEXUAL HISTORY

- | | |
|--|--|
| <input type="checkbox"/> Are you sexually active | <input type="checkbox"/> Recent new sexual partner |
| <input type="checkbox"/> History of sexual abuse | <input type="checkbox"/> Began sexual intercourse before the age of 16 |
| <input type="checkbox"/> History of sexually transmitted infection | <input type="checkbox"/> Pain during sex |
| <input type="checkbox"/> History of multiple sexual partners (5 or more) | <input type="checkbox"/> Chance you might be pregnant today |

MENSTRUATION N/A, no periods/reason:

First day of your last period: _____ **How often do you have periods:** Every _____ days
Age at first menstrual period: _____ **Lasting** _____ **days.**
Irregular periods No Yes **Is your flow:** light moderate heavy
Bleeding/spotting between periods No Yes **Pass clots with periods:** small large

CURRENT METHOD OF PREVENTING PREGNANCIES

- | | | | |
|---|--|---|------------------------------------|
| <input type="checkbox"/> None (unprotected intercourse) | <input type="checkbox"/> Depo Provera | <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Condoms |
| <input type="checkbox"/> Natural family planning | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal |
| <input type="checkbox"/> IUD / Nexplanon | <input type="checkbox"/> Partner Vasectomy | <input type="checkbox"/> Foam/gel/suppository | <input type="checkbox"/> Diaphragm |

PREGNANCY HISTORY

No changes since last visit
of pregnancies _____ # of miscarriages: _____ # of deliveries: _____ # of abortions: _____
of living children: _____ Type of deliveries: # _____ Vaginal # _____ C-section
Any pregnancy complications including preterm deliveries: _____

Surgical History & dates

No changes from last visit
List all previous hospitalizations, surgeries, and procedures:

Have you had Ovarian, or Uterine Cancer? No Yes If yes, when were you diagnosed: _____

Current Medications:

No changes from last visit

PHARMACY

Please let us know your preferred pharmacy and location:

Please complete
the
following side →

Family Medical History

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

Has any blood relative ever had:	No	Maternal Relative (specify)	Paternal Relative (specify)	Has any blood relative ever had:	No	Maternal Relative (specify)	Paternal Relative (Specify)
Blood Disorder				Cancer (specify)			
Deep Vein Thrombosis				Breast cancer			
Stroke				Colon cancer			
				Ovarian cancer			

Medication Allergies: No allergies to medications

LATEX ALLERGY

SOCIAL / SUBSTANCE USE

Tobacco: never quit 1/2ppd 1ppd 1ppd+

Alcohol: never current # _____/week, # _____/month

Caffeine: never current # _____/week, # _____/month

Street Drugs: Current Past

Marijuana: Current Past

In the last year, have you had any...

- | | | |
|---|---|---|
| <input type="checkbox"/> Recent weight gain <input type="checkbox"/> loss | <input type="checkbox"/> New lesions | <input type="checkbox"/> Frequent headaches/Migraine |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Change in moles: <input type="checkbox"/> Color <input type="checkbox"/> Shape | <input type="checkbox"/> Bone Density Testing |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Itching <input type="checkbox"/> Irritation | Last Date: _____ |
| <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Hormone therapy | <input type="checkbox"/> Was it normal |
| <input type="checkbox"/> Currently breast feeding | If yes, what type: _____ | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Mammogram | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Night sweats |
| Last date: _____ | <input type="checkbox"/> Facial hair growth | <input type="checkbox"/> Attempt(s) to hurt yourself/others |
| <input type="checkbox"/> Was it normal? | <input type="checkbox"/> Intolerant to heat and cold | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Have you had breast cancer? | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Chest pain or angina | <input type="checkbox"/> Bleeding with bowel movements | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Incontinence of stool | <input type="checkbox"/> Frequent nosebleeds |
| | | <input type="checkbox"/> History of blood transfusion |

OTHER Any other problems/questions?

ID# _____



Staff Initials _____

PATIENT INFORMATION FORM

First and Last Name		Maiden (if married)	Date of Birth	Social Security Number
Address		City	State	Zip
Race	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Primary Language	Religion
Employer			Occupation	
Primary Care Physician/Location			Are we authorized to fax any office notes they request to them? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cell Phone Number	Home Phone Number		Email Address	

I give my permission to South Shore Women's Health Care staff to call and leave detailed information regarding my appointment, test results, prescriptions, outstanding balance, or care in a message on the following phone(s):

 Home Phone Cell Phone Patient Portal

I would prefer to receive my appointment reminders by: Text Message or Email or Patient Portal
*Standard text messaging fees may apply depending on your cellular service plan

Spouse or Guardian Information *(Guardian information required for patients under 18 years old)*

Full Name	Date of Birth	Phone
May we speak with them about your health? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you want them as your emergency contact? <input type="checkbox"/> Yes <input type="checkbox"/> No

INSURANCE

Primary Insurance	Policy Holder <i>(if different from you)</i>	Their Date of Birth	Relationship to you
Secondary Insurance	Policy Holder <i>(if different from you)</i>	Their Date of Birth	Relationship to you

HIPAA

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of *South Shore Women's Health Care* to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

First and Last Name	Relationship	Phone Number	Do you want them as your emergency contact?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient Information: I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient. You have the right to revoke this consent in writing. My signature below signifies that I have read and understand South Shore Women's Health Care's financial and HIPAA (protected health information) policy. Furthermore, it acknowledges my responsibility regarding charges related to my care.

Patient/Guardian Signature _____

Date: _____

Patient/Guardian's Printed Name _____