Put a ✓ if it applies to you

South Shore Obstetrics & Gynecology Women's Health Care

ID# _____

Review of Systems

Name:_____ **DOB: (_____/_____/_____)**

GENITOURINARY

- ☐ Any abnormal pap smears, in past 3 years
- ☐ Pelvic pain
- ☐ Vaginal ☐ dryness ☐ itching
- ☐ Frequent urination
- ☐ Nighttime urination
- ☐ Blood in urine
- ☐ Vaginal odor
- ☐ Burning/painful urination
- ☐ Involuntary loss of urine
- ☐ Bleeding w/ bowel movements
- ☐ Black Tarry Stools

SEXUAL HISTORY

- ☐ Are you sexually active
- ☐ History of sexual abuse
- ☐ History of sexually transmitted infection
- ☐ History of multiple sexual partners (5 or more)
- ☐ Recent new sexual partner
- ☐ Began sexual intercourse before the age of 16
- ☐ Pain during sex
- ☐ Chance you might be pregnant today

MENSTRATION ☐ N/A, no periods/reason:

First day of your last period: _____

Age at first menstrual period: _____

Irregular periods No Yes

Bleeding/spotting between periods No Yes

How often do you have periods: Every _____ days

Lasting _____ days.

Is your flow: ☐light ☐moderate ☐heavy

Pass clots with periods: ☐ small ☐ large

CURRENT METHOD OF PREVENTING PREGNANCIES

- ☐ None (unprotected intercourse)
- ☐ Natural family planning
- ☐ IUD / Nexplanon
- ☐ Depo Provera
- ☐ Withdrawal
- ☐ Partner Vasectomy
- ☐ Oral contraceptives
- ☐ Hysterectomy
- ☐ Foam/gel/suppository
- ☐ Condoms
- ☐ Tubal
- ☐ 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...

☐ Recent weight ☐ gain ☐ loss

☐ Breast tenderness

☐ Breast lumps

☐ Nipple discharge

☐ Currently breast feeding

☐ **Mammogram**

Last date: _____

☐ Was it normal?

☐ Have you had breast cancer?

☐ Chest pain or angina

☐ Difficulty breathing

☐ New lesions

☐ Change in moles: ☐Color ☐Shape ☐Itching ☐Irritation

☐ Hormone therapy

If yes, what type: _____

☐ Hair loss

☐ Facial hair growth

☐ Intolerant to heat and cold

☐ Dry Skin

☐ Bleeding with bowel movements

☐ Incontinence of stool

☐ Frequent headaches/Migraine

☐ ***Bone Density Testing***

Last Date: _____

☐ Was it normal

☐ Hot flashes

☐ Night sweats

☐ Attempt(s) to hurt yourself/others

☐ Depression

☐ Panic attacks

☐ Anemia

☐ Frequent nosebleeds

☐ History of blood transfusion

OTHER Any other problems/questions?

ID# _____

Staff Initials _____

South Shore Obstetrics & Gynecology Women's Health Care

PATIENT INFORMATION FORM

First and Last Name	Maiden (if married)	Date of Birth	Social Security Number
Address	City	State	Zip

Race	Ethnicity	☐Married ☐Divorced ☐Single ☐Widowed	Primary Language	Religion
	☐ Hispanic ☐ Not Hispanic			

Employer	Occupation
Primary Care Physician/Location	Are we authorized to fax any office notes they request to them? ☐Yes ☐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?	Do you want them as your emergency contact?
☐Yes ☐No	☐Yes ☐No

INSURANCE

Primary Insurance	Policy Holder *(if different from you)*	Their Date of Birth	Relationship to you
Secondary Insurance	Policy Holder *(if different from you)*	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?
			☐Yes ☐No
			☐Yes ☐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 _____