Put a ✓ if it applies to you

South Shore Obstetrics & Gynecology Women's Health Care

ID# _____

Staff Initials _____

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

CONSTITUTIONAL	
	Regular exercise
	Recent weight ☐ gain ☐ loss
	Chronic fatigue

EYES	
	Glaucoma
	Blurred vision
	Double vision
	Do you wear glasses/contacts

HENT	
	Dizziness
	Impaired hearing
	Frequent mouth sores
	Frequent sore throats

BREASTS	
	Breast tenderness
	Breast lumps
	Nipple discharge
	Currently breast feeding
	Mammogram
	Last date:
	Was it normal?
	Have you had breast cancer?

CARDIOVASCULAR	
	Chest pain or angina
	Heart attack
	Heart murmur
	Shortness of breath
	Swelling of hands, feet, or ankles
	Varicose veins
	Inflammation of veins or clots in legs

RESPIRATORY	
	Difficulty breathing
	Wheezing
	Coughing up blood
	Current common "cold symptoms"

PHARMACY
Please let us know your preferred pharmacy and location:

GASTROINTESTINAL	
	Loss of appetite
	Heartburn or indigestion
	Vomiting Blood
	Pain in the abdomen
	Gallbladder disease
	Removed:
	Hemorrhoids
	Constipation
	Diarrhea
	Painful bowel movements
	Bleeding with bowel movements
	Black/tarry stools
	Incontinence of stool
	Have you had Colon Cancer

SKIN	
	New lesions
	Change in moles: ☐Color ☐Shape
	☐Itching ☐Irritation
	Rashes
	Frequent infections or boils

NEUROLOGICAL	
	Frequent headaches/Migraine
	Current or past fainting spells
	Memory difficulties
	Balance difficulties
	Seizures
	Tremors
	Numbness or tingling

MUSCULOSKELETAL	
	Any physical disabilities
	Frequent back pain
	Joint pain
	Bone Density Testing
	Last Date:
	Was it normal

ENDOCRINE	
	Hormone therapy
	If yes, what type:
	Hair loss
	Facial hair growth
	Intolerant to heat and cold
	Dry Skin
	Excessive thirst
	Excessive urination

ENDOCRINE (continued)	
	Hot flashes
	Night sweats
	Thyroid Testing
	Date:

MENTAL HEALTH	
	Psychiatric diagnosis
	Hospitalized for psychiatric reason
	Attempt(s) to hurt yourself/others
	Depression
	Panic attacks
	Anxiety
	Difficulty sleeping
	Eating disorders
	Other:

HEMATOLOGICAL / LYMPHATIC	
	Anemia
	Experience excessive bleeding
	Frequent nosebleeds
	Do you bruise easily
	History of blood transfusion
	Unusual swelling or lumps

ALLERGIC/IMMUNOLOGIC	
	Seasonal allergic symptoms
	Tetanus immunization last 10 yrs

SOCIAL / SUBSTANCE USE

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

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

Street Drugs: ☐never ☐ minimal ☐ moderate ☐ heavy

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

Please complete the following side →

GENITOURINARY	
	Any abnormal pap smears, in past 3 years
	Pelvic pain
	Vaginal ☐ dryness ☐ itching
	Vaginal odor
	Burning/painful urination
	Involuntary loss of urine
	Frequent urination
	Nighttime urination
	Blood in urine

MENSTRATION ☐ **N/A**, no periods/reason:

First day of your last period:

Age at first menstrual period:

Irregular periods	No	Yes

How often do you have periods: every ___ days

Lasting ___ days. **Is your flow**: ☐light ☐moderate ☐heavy

Bleeding/spotting between periods	No	Yes

Pass clots with periods: ☐ small ☐ large

OTHER

Any other problems/questions?

Medication Allergies: ☐No allergies to medications

☐ LATEX ALLERGY

Current Medications: ☐No changes from last visit

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

CURRENT METHOD OF PREVENTING PREGNANCIES

☐ None (unprotected intercourse)

☐ Natural family planning ☐ Withdrawal

☐ IUD ☐ Foam/gel/suppository ☐ Diaphragm

☐ Depo Provera ☐ Oral contraceptives ☐ Condoms

☐ Hysterectomy ☐ Partner Vasectomy ☐ Tubal

Surgical History & dates ☐No changes from last visit

List all previous hospitalizations, surgeries, and procedures:

Have you had Ovarian, or Uterine Cancer?	No	Yes

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:

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)**
Asthma				Stroke			
Birth Defect				Psychiatric disease			
Blood Disorder				Thyroid disease / Goiter			
Deep Vein Thrombosis				**Cancer (*specify*)**			
Diabetes				Breast cancer			
Heart disease (specify)				Colon cancer			
High blood pressure				Ovarian cancer			

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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 _____