Put a ✓ if it applies to you

South Shore Obstetrics & Gynecology Women's Health Care

ID# ________________

Staff Initials _________

Name	DOB: (/ /)	Preferred Pharmacy:

	CONSTITUTIONAL
	Seat belt use
	Regular exercise
	Recent weight ☐ gain ☐ loss
	Chronic fatigue
	EYES
	Eye injury
	Glaucoma
	Blurred vision
	Double vision
	Do you wear glasses/contacts
	HENT
	Dizziness
	Frequent sinus infections
	Ear problems
	Impaired hearing
	Frequent itchy/running nose
	Frequent nose bleeds
	Frequent mouth sores
	Frequent sore throats
	Hoarseness
	BREASTS
	Monthly self exams
	Breast tenderness
	Breast swelling
	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 with movement
	Shortness of breath all the time
	Swelling of hands, feet, or ankles
	Varicose veins
	Inflammation of veins or clots in legs
	Recent cholesterol/lipid testing
	Testing done by your family doctor
	Respiratory
	Difficulty breathing
	Wheezing
	Coughing up blood
	Current common "cold symptoms"

	RESPIRATORY continued
	Chronic cough
	Frequent bronchitis
	GASTROINTESTINAL
	Loss of appetite
	Heartburn or indigestion
	Vomiting Blood
	Cramping or pain in the abdomen
	Gallbladder disease
	Removed:
	Hemorrhoids
	Constipation
	Frequent diarrhea
	Change in bowel habits
	Painful bowel movements
	Bleeding with bowel movements
	Black/tarry stools
	Incontinence of stool
	Colonoscopy Last date:
	Was it normal?
	Have you had Colon Cancer
	SKIN
	New lesions
	Change in moles: ☐Color ☐Shape ☐Itching ☐Irritation
	Rashes
	Eczema
	Psoriasis
	Frequent infections or boils
	Jaundice (yellow skin and eyes)
	Tanning bed use
	NEUROLOGICAL
	Frequent headaches
	Current or past fainting spells
	Memory difficulties
	Balance difficulties
	Seizures
	Tremors
	Lack of coordination
	Numbness or tingling
	MUSCULOSKELETAL
	Any physical disabilities
	Frequent back pain
	Joint pain
	Joint Stiffness
	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
	Skin is overly dry
	Excessive thirst
	Excessive urination
	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
	Do you bruise easily
	History of blood transfusion
	Unusual swelling or lumps
	ALLERGIC/IMMUNOLOGIC
	Seasonal allergic symptoms
	History of Chickenpox or immunity
	Are you sick a lot
	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

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
	Foul smelling urine
	Blood in urine
	Change in urine color

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

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				Gastrointestinal Disease			
Birth Defect				Heart disease (specify)			
Blood Disorder				Hepatitis (specify type)			
Deep Vein Thrombosis				High blood pressure			
Diabetes				Liver disease			
Cancer (*specify*)				Kidney disease (specify)			
Breast cancer				Psychiatric disease			
Colon cancer				Thyroid disease / Goiter			
Ovarian cancer				Tuberculosis			

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PATIENT INFORMATION FORM

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

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

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
Employer	Occupation	May we speak with him/her about your health? ☐ YES ☐ NO

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
			☐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 ______________________________________

South Shore Obstetrics & Gynecology Women's Health Care

ID# ________________

Provider Initials ________________

Name: ______________________ DOB: _______________ Date: ______________________

Patient Depression Screening for Teens (PHQ-9T)

	Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or plesure in doing things	0	1	2	3
2	Feeling down, depressed, irritable, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite, weight loss, or overeating	0	1	2	3
6	Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things like school work, reading, or watching TV	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	Add columns				
	TOTAL SCORE				

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

In the past year, have you felt depressed or sad most days. even if you felt okay sometimes? **Y** **N**

Has there been a time in the past month when you have had serious thoughts about ending your life? **YES** **NO**

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? **YES** **NO**

Patient Anxiety Screening (GAD-7)

	Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid afs if something awful might happen	0	1	2	3
	Add columns				
	TOTAL SCORE				
8	If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult