

Put a ✓ if it applies to you

Name		DOB: (/ /)	Preferred Pharmacy:	
CONSTITUTIONAL		RESPIRATORY continued	ENDOCRINE	
Seat belt use		Chronic cough	Hormone therapy	
Regular exercise		Frequent bronchitis	If yes, what type:	
Recent weight <input type="checkbox"/> gain <input type="checkbox"/> loss		GASTROINTESTINAL		
Chronic fatigue		Loss of appetite	Hair loss	
EYES		Heartburn or indigestion	Facial hair growth	
Eye injury		Vomiting Blood	Intolerant to heat and cold	
Glaucoma		Cramping or pain in the abdomen	Skin is overly dry	
Blurred vision		Gallbladder disease	Excessive thirst	
Double vision		Removed:	Excessive urination	
Do you wear glasses/contacts		Hemorrhoids	Hot flashes	
HENT		Constipation	Night sweats	
Dizziness		Frequent diarrhea	Thyroid Testing	
Frequent sinus infections		Change in bowel habits	Date:	
Ear problems		Painful bowel movements	MENTAL HEALTH	
Impaired hearing		Bleeding with bowel movements	Psychiatric diagnosis	
Frequent itchy/running nose		Black/tarry stools	Hospitalized for psychiatric reason	
Frequent nose bleeds		Incontinence of stool	Attempt(s) to hurt yourself/others	
Frequent mouth sores		Colonoscopy Last date:	Depression	
Frequent sore throats		Was it normal?	Panic attacks Anxiety	
Hoarseness		Have you had Colon Cancer	Difficulty sleeping	
BREASTS		SKIN		
Monthly self exams		New lesions	Other:	
Breast tenderness		Change in moles: <input type="checkbox"/> Color <input type="checkbox"/> Shape		
Breast swelling		<input type="checkbox"/> Itching <input type="checkbox"/> Irritation		
Breast lumps		Rashes	HEMATOLOGICAL / LYMPHATIC	
Nipple discharge		Eczema	Anemia	
Currently breast feeding		Psoriasis	Experience excessive bleeding	
Mammogram		Frequent infections or boils	Do you bruise easily	
Last date:		Jaundice (yellow skin and eyes)	History of blood transfusion	
Was it normal?		Tanning bed use	Unusual swelling or lumps	
Have you had breast cancer?		NEUROLOGICAL		
CARDIOVASCULAR		Frequent headaches	ALLERGIC/IMMUNOLOGIC	
Chest pain or angina		Current or past fainting spells	Seasonal allergic symptoms	
Heart attack		Memory difficulties	History of Chickenpox or immunity	
Heart murmur		Balance difficulties	Are you sick a lot	
Shortness of breath with movement		Seizures	Tetanus immunization last 10 yrs	
Shortness of breath all the time		Tremors	SOCIAL / SUBSTANCE USE	
Swelling of hands, feet, or ankles		Lack of coordination	Tobacco: <input type="checkbox"/> never <input type="checkbox"/> quit	
Varicose veins		Numbness or tingling	<input type="checkbox"/> 1/2ppd <input type="checkbox"/> 1ppd <input type="checkbox"/> 1ppd+	
Inflammation of veins or clots in legs		MUSCULOSKELETAL		
Recent cholesterol/lipid testing		Any physical disabilities	Alcohol: <input type="checkbox"/> never <input type="checkbox"/> current	
Testing done by your family doctor		Frequent back pain	# /week, # /month	
Respiratory		Joint pain	Street Drugs: <input type="checkbox"/> never <input type="checkbox"/> minimal	
Difficulty breathing		Joint Stiffness	<input type="checkbox"/> moderate <input type="checkbox"/> heavy	
Wheezing		Bone Density Testing	Caffeine: <input type="checkbox"/> never <input type="checkbox"/> current	
Coughing up blood		Last Date:	# /week, # /month	
Current common "cold symptoms"		Was it normal		

GENITOURINARY

Any abnormal pap smears, in past 3 years
Pelvic pain
Vaginal <input type="checkbox"/> dryness <input type="checkbox"/> itching
Vaginal odor
Burning/painful urination
Involuntary loss of urine
Frequent urination
Nighttime urination
Foul smelling urine
Blood in urine
Change in urine color

MENSTRUATION 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: <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy		
Bleeding/spotting between periods	No	Yes
Pass clots with periods: <input type="checkbox"/> small <input type="checkbox"/> 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				

ID# _____

Staff Initials _____



PATIENT INFORMATION FORM

First and Last Name		Maiden (if married)	Date of Birth	Social Security Number
Address		City	State	Zip
Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	Race	<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
Employer	Occupation	May we speak with him/her about your health? <input type="checkbox"/> YES <input type="checkbox"/> 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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<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 _____

Name: _____

DOB: _____

Date: _____

Patient Depression Screening (PHQ-9)					
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 pleasure in doing things	0	1	2	3
2	Feeling down, depressed, 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 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, such as reading a book or watching television	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	0	1	2	3
		Add columns			
		TOTAL SCORE			
10	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

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 as 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