Welcome to Our Practice

At South Shore Women’s Health we provide comprehensive Gynecologic and Obstetric services on Boston’s South Shore. Our practice consists of seven Obstetrician Gynecologists, four Nurse Practitioners, and three Physician Assistants. We are affiliated with South Shore Hospital in Weymouth, Massachusetts.

We provide a full range of gynecologic care including routine exams, preconceptual counseling, pap smear evaluation, STD screening, birth control counseling, the evaluation of abnormal menstrual cycles, PMS treatment, and menopause care. It is also our privilege to provide obstetric care throughout pregnancy and birth.

Our philosophy is one of patient education and provider-patient teamwork to reach our common goal (your good health!) All patients may choose to see either a physician, a nurse practitioner, or a physician assistant as their primary provider. Please visit our web site at www.southshorewomenshealth.com for more information about our providers and our services.

Pre-registration
We have enclosed our patient registration and medical history forms. It would be greatly appreciated if you would take the time to complete them prior to your visit. You may either fax them to our office or bring them with you for your appointment.

Insurance
South Shore Women’s Health participates with the following insurance plans. Please click on the individual plan name to obtain more information about general requirements. It is the responsibility of patients to know their individual benefits, so please consult your plan directly if you have questions regarding coverage of specific services.

As of January 1st, 2001, referrals are no longer required by plans for most Ob/Gyn services in Massachusetts. However “self-funded” plans and MassHealth may require referrals, and some services, such as infertility also still require referrals. Check with your insurance carrier for further information about their policies for referrals.
Insurance Plans
Aetna  Blue Shield  CIGNA  Fallon Community Plan  Network Health  MassHealth  First Health  Great West Health Care  Harvard Pilgrim Health Care  Humana/Choicecare  Medicare  Neighborhood Health Plan  Private Health Care System  Tufts Health Plan  Unicare  United Health Care  BMC Healthnet

We will request your co-payment during the registration process.

Appointments
Office visits are by appointment only. The scheduler may ask you about your illness or the reason for your visit in order to adequately schedule the physician’s time. If you feel that you need to be seen on an urgent basis, you will be connected with our triage nurse.
As a new patient, please arrive 15 minutes early for your appointment so that we can process your information into our system. Be sure and bring your insurance card and a photo ID for identification purposes.

Cancellations
If you are unable to keep an appointment, please notify us at least 24 hours in advance. This will allow us to give your appointment slot to another patient. We will remind you of your appointment 24 – 48 hours in advance.

No Show – A missed appointment with no notice of cancellation
We understand that on occasion an appointment can be forgotten. It leaves your provider with an empty slot in their schedule and unable to see another patient. Both your time and your provider’s time are valuable. With that in mind, please note that a continued pattern of not showing for appointments may result in your inability to pre-book future appointments.

Prior to your visit, if you have any questions regarding are policies or the enclosed forms please do not hesitate to call us for assistance.
**PATIENT MEDICAL HISTORY FORM**

Patient Name: _____________________________ DOB: _______________

Primary Care Physician: ___________________________ Phone #: (_____) ____________________

Reason for referral / appointment: __________________________________________________________

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**MENSTRUAL HISTORY** (Complete even if post-menopausal or no longer having periods)

Age at first period: ____________

If your menstrual periods are regular; periods start every: ____________ days

If your menstrual periods are irregular; periods start every: _______ to _______ days (e.g., 12 to 60)

Duration of bleeding: _______ days

Does bleeding or spotting occur between periods?  □ Yes  □ No

Does bleeding or spotting occur after intercourse?  □ Yes  □ No

First day of last menstrual period ________________________________  Menopause:  □ Yes  □ No

Month / Day / Year

Do you have pain associated with periods?  □ Yes  □ No  □ Occasionally

If yes, is the pain before?  □ Yes  □ No  □ During?  □ Yes  □ No

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**PREGNANCY HISTORY** (Please list ALL pregnancies)  □ Never been pregnant

**OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES**

<table>
<thead>
<tr>
<th>Year</th>
<th>Place of Delivery</th>
<th>Duration of Pregnancy</th>
<th>Hours of Labor</th>
<th>Type of Delivery</th>
<th>Complications Mother/Infant</th>
<th>Infant Sex</th>
<th>Infant Weight</th>
<th>Present Health of child</th>
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**PREGNANCY RISK FACTORS:** Fill out this Section only if you are pregnant or planning to become pregnant in the near future

Have you or the baby’s father or anyone in your families ever had any of the following:

- Down Syndrome (Mongolism)?  If yes, who?
- Other Chromosomal abnormality?  If yes, specify and who?
- Neural tube defect (spina bifida, anencephaly)?  If yes, specify and who?
- Hemophilia or other coagulation abnormality?  If yes, specify and who?
- Muscular Dystrophy?  If yes, who?
- Cystic Fibrosis?  If yes, who?
Patient Name: ______________________________________________  DOB: ________________

BIRTH CONTROL HISTORY
What birth control method(s) do you currently use? ________________________________________________________
What birth control method(s) have you used in the past? ____________________________________________________

SEXUAL HISTORY
Have you ever had a sexual partner? □ Yes □ No  Age you became sexually active? ________________

HEALTH HISTORY
☐ Liver Disease (including hepatitis)  ☐ Thyroid disease  ☐ Bronchitis
☐ Epilepsy  ☐ Asthma  ☐ HIV +
☐ Blood Transfusions  ☐ Emphysema  ☐ Eating Disorder
☐ Other: _________________________________________________________________________

CURRENT MEDICATIONS (Please list ALL medications. Please use back of form if more room is needed.)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Prescribed By</th>
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Pharmacy Information:
Name: ________________________________  Address: ___________________________________________________
Phone: ________________________________

OVER THE COUNTER MEDICATIONS / VITAMINS / SUPPLEMENTS – Please List ALL

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Taken for</th>
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</tbody>
</table>

ALLERGIES: Please list ALL known allergies -or- ☐ None

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction / Symptoms</th>
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</table>
### SOCIAL HISTORY:

- **Do you smoke:** 
  - ☐ Yes
  - ☐ No
  - Packs per day: ______ / cigarettes per day: ______
  - How many years: ______

- **Drink alcohol:** 
  - ☐ Yes
  - ☐ No
  - Wine (glasses/day): ______
  - Beer (bottles/day): ______
  - Hard Liquor (oz./day): ______

- **Use street drugs:** 
  - ☐ Yes
  - ☐ No
  - Type: _______________
  - Amount: _______________
  - How often: _______________

- **Exercise:** 
  - ☐ Yes
  - ☐ No
  - Type: ______________________________
  - How often: ____________________________

- **Your occupation:** _______________________________________________________________________________________

- **Employer:** _____________________________________________________________________________________________

- **Marital Status:**
  - ☐ Married
  - ☐ Single
  - ☐ Widow
  - ☐ Divorced
  - ☐ Separated

- **Do you feel threatened or unsafe in your current relationship?** ___________________________________________________________________________________________

- **Do you have a history of:**
  - Emotional abuse: ☐ Yes
  - ☐ No
  - Sexual abuse: ☐ Yes
  - ☐ No
  - Physical abuse: ☐ Yes
  - ☐ No
  - Verbal abuse: ☐ Yes
  - ☐ No

  ___________________________________________________________________________________________________________

### FAMILY HISTORY

- Please check all that apply

- ☐ Diabetes
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Bleeding Disorder
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ High Cholesterol
- ☐ Thyroid Disease
- ☐ Heart Disease
- ☐ Colonic Cancer
- ☐ Genetic Disorder
- ☐ Endometrial Cancer
- ☐ Other: __________________________________________________________________________________________

If “yes” to any, please list affected relatives and which disease applies:

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

### OTHER SYMPTOMS

- Please check all that apply and list the year

- ☐ None

- Have you recently experienced:

  - ☐ Weight Loss
  - ☐ Weight Gain
  - ☐ Breast Discharge
  - ☐ Hair Growth
  - ☐ Change in energy
  - ☐ Other: ______________
  - ☐ Hair Loss
  - ☐ Change in urinary function
  - ______________________
  - ☐ Change in exercise tolerance
  - ☐ Hot Flashes / Flashing
  - ______________________
**PAST OBSTETRICAL / GYNECOLOGICAL SURGERIES** Please check all that apply

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Year</th>
<th>Economy</th>
<th>Surgery</th>
<th>Year</th>
<th>Economy</th>
</tr>
</thead>
<tbody>
<tr>
<td>D&amp;C</td>
<td>_____</td>
<td></td>
<td>Ovarian Surgery</td>
<td>_____</td>
<td></td>
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<tr>
<td>Hysteroscopy</td>
<td>_____</td>
<td></td>
<td>L cyst(s) removed ovarian</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Infertility Surgery</td>
<td>_____</td>
<td></td>
<td>R cyst(s) removed ovarian</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Tuboplasty</td>
<td>_____</td>
<td></td>
<td>L ovary removed</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>_____</td>
<td></td>
<td>R ovary removed</td>
<td>_____</td>
<td></td>
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<tr>
<td>Laparoscopy</td>
<td>_____</td>
<td></td>
<td>Vaginal or bladder repair</td>
<td>_____</td>
<td></td>
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<tr>
<td>Hysterectomy</td>
<td>_____</td>
<td></td>
<td>for: Prolapsed or incontinence</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Abdominal or Vaginal</td>
<td>_____</td>
<td></td>
<td>Cesarean Section</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Myomectomy</td>
<td>_____</td>
<td></td>
<td>Other (Specify):</td>
<td>_____</td>
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</tr>
</tbody>
</table>

**PAST SURGICAL HISTORY (Not OB/GYN)**

Please list all surgeries and the year performed

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Year</th>
</tr>
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<tbody>
<tr>
<td>None</td>
<td></td>
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</tbody>
</table>

**PAP SMEAR / MAMMOGRAM HISTORY**

Date of last PAP smear? ___________ Date of last Annual Wellness Exam: ___________
Have you ever had an abnormal PAP smear? Yes ☐ No ☐
Have you ever had treatment for an abnormal pap smear? Yes ☐ No ☐
If yes, what type(s) of treatment have you had?

Check all that apply:
- Cryotherapy ☐ Yes ☐ No ☐
- Cone Biopsy ☐ Yes ☐ No ☐
- Colposcopy ☐ Yes ☐ No ☐
- Loop Excision (LEEP) ☐ Yes ☐ No ☐

**OTHER PAST GYNECOLOGICAL HISTORY** Please check all that apply or ☐ None

<table>
<thead>
<tr>
<th>Condition</th>
<th>Year Treated</th>
<th>Year Treated</th>
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</thead>
<tbody>
<tr>
<td>Venereal Warts</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Herpes – Genital</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
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<tr>
<td>Syphilis</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
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<tr>
<td>Pelvic Inflammatory disease</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
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<tr>
<td>Other:</td>
<td>___________</td>
<td>___________</td>
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</tbody>
</table>
Patient Name: ______________________________________________  DOB: ____________________________________________

PERSONAL MEDICAL HISTORY  Please check all that apply  ☐ None
☐ Arthritis  ☐ High Blood Pressure  ☐ Kidney Disease
☐ Diabetes  ☐ Heart Disease  ☐ Gallstones

__________________________________________________________________________________________________

OTHER SCREENING EXAMINATIONS:
Date of last Colonoscopy: _____________________________ Performed by: ___________________________________

Date of last Bone Density Scan (DEXA): ___________________________ Location: _____________________________

__________________________________________________________________________________________________

ADDITIONAL COMMENTS / CONCERNS: Please list any additional comments, concerns or questions you would like to be addressed by your provider.

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Patient Signature: __________________________________________ Date: ________________________

__________________________________________________________________________________________________

STAFF REVIEW:
Comments:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Nurse Signature: _________________________________________ Date: ________________________
Name: ___________________________________________  Maiden Name: ___________________  DOB: ____________________

Last                                                           First                                      MI

Mailing Address: ___________________________________________________________  Marital Status: ______________  SS#: __________________

Street                                                                                           Town            State            Zip

Cell Phone: _______________________ Home Phone: _______________________  Email: __________________________________

Employer: _______________________________________________________________  Occupation: __________________________

Address: _______________________________________________________________  Work Phone #: _____________________

Street                                                                                                                  Town            State            Zip

Primary Care Physician/Referring Physician: ___________________________________________________________________

Preferred Pharmacy Name/Aдрес: ___________________________________________________   Phone #:_____________________

Race
_____ American Indian or Alaska Native   _____ White
_____ Asia           _____ Black or African American
_____ More than one race   _____ Native Hawaiian
_____ Other Pacific Islander   _____ Other

Ethnicity
_____ Hispanic or Latino
_____ Not Hispanic or Latino

Primary Language: __________________________________________________________________

Insurance Information

Insurance Coverage: Yes ____   No __________

Name of Insurance: _______________________________________

Type of Plan: HMO ____   PPO ____ Other ____

Company Name if Group Policy: _______________________________

Subscriber: _____________________________________________

Subscriber Date of Birth: _________________________________

Subscriber Soc. Sec. #: __________________________________

Relationship: Self ____   Spouse ____   Child ____   Other ____

Policy Number: ______________  Member Number: _____________

Group Number:  _________________________________________

If MassHealth: Recipient ID Number: ______________________

Managed Care Org: ________________________

If you have a second insurance, indicate below:

Name of Insurance: _______________________________________

Subscriber: _____________________________________________

Subscriber Date of Birth: _________________________________

Relationship: Self ____   Spouse ____   Child ____   Other ____

Policy Number: ______________  Member Number: _____________

Group Number:  _________________________________________

Guarantor (Person who has financial responsibility)   Same as Subscriber?   Yes ____   No __________

Name: ___________________________________________________________

Address: _________________________________________________________  Relationship: __________  Home Phone #: ____________________

Employer: _________________________________________________________  Employer Phone#: ____________________

Name of nearest relative not living with you

Name: _____________________________________________________________  Relationship: __________

Address: _________________________________________________________  Home Phone #: ____________________

Medical Information and Payment Authorization

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor group indicated on the claim. I understand I am financially responsible for any balance not covered by my carrier. A copy of this signature is as valid as the original.

Signature: ___________________________________________  Date: ____________________

How did you hear about our office?

☐ Friend/Family  ☐ Referral  ☐ Health Fair   ☐ Newspaper   ☐ Magazine  ☐ Website   ☐ Other __________________________

Which newspaper / magazine? _____________________________
ACKNOWLEDGEMENT / RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form I acknowledge the receipt / reading of South Shore Women’s Health, PC, Notice of Privacy Practices (Reception Room plaque or brochure) which provides me with detailed information about how South Shore Women’s Health, PC may use and disclose my protected health information for the purposes of treatment, payment and health care operations.

In addition, by signing below, I understand that I hereby authorize the Practice to disclose my medical information so that the Practice may treat, seek payment from third parties for such treatment, and generally carry on the Practice’s health care operations.

Patient’s Signature:__________________________ Date:________________

Patient’s Name:________________________________________ DOB:__________________
(Printed Name)

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS AND / OR OTHER REPRESENTATIVES

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
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Patient’s Signature:________________________________________ Date:__________________