



Brookwood
Women's Health, P.C.

ACCT# _____

WT: _____

BP: _____

OFFICE USE ONLY

TODAY'S DATE _____

PLEASE CIRCLE THE DOCTOR YOU ARE HERE TO SEE: FREEMAN MORGAN ROUTMAN STRAUGHN DEISHER

LAST NAME _____ FIRST NAME _____

DOB _____ Pharmacy Name & Address: _____

CIRCLE THE PURPOSE OF YOUR VISIT: Annual Exam Annual Exam & Other Reason Office Visit Post-Partum/Post OP

What problems or issues would you like to discuss today? _____

When was the first day of your last menstrual cycle? _____

Do you smoke? Yes/How many _____ No

Do you drink alcohol? Yes/How much _____ No

Any recreational drugs? _____

Sexually active? Yes No

Do you exercise? Yes/Frequency _____ No

PLEASE LIST ALL OF YOUR MEDICATIONS YOU ARE CURRENTLY TAKING, PRESCRIPTION & OVER THE COUNTER:

What contraceptive or hormone replacement therapy are you using?

ARE YOU ALLERGIC TO ANY DRUGS? YES/IF SO LIST _____ No

Do you have a primary care doctor? Yes/Name _____ No

Last Mammogram? _____ Last Colonoscopy? _____ Last Bone Scan? _____

MEDICAL HISTORY: Please list any NEW medical problems since your last Annual:

SURGICAL HISTORY: Please list any NEW surgeries/hospitalizations and dates performed since last Annual:

FAMILY HISTORY: Please list any NEW OR ANY CHANGES to your family history since last Annual:

OVER

ANNUAL/GYN

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU:

CONSTITUTIONAL

Weight Loss.....☐
Weight Gain.....☐
Fever.....☐
Fatigue.....☐

EYES

Vision changes.....☐
Wear glasses or contacts.....☐

ENT

Headaches.....☐
Sinus Problems.....☐

CARDIOVASCULAR

Chest Pain.....☐
Difficult breathing on exertion.....☐
Swelling of legs.....☐
Palpitations.....☐

RESPIRATORY

Wheezing.....☐
Spitting up blood.....☐
Shortness of breath.....☐
Cough.....☐

GASTROINTESTINAL

Diarrhea, frequent.....☐
Bloody Stool.....☐
Nausea or vomiting.....☐
Constipation.....☐

GENITOURINARY

Blood in urine.....☐
Pain with urination.....☐
Involuntary loss of urine.....☐
Frequency of urination.....☐
Incomplete emptying.....☐

MUSCULOSKELETAL

Muscle weakness.....☐

BREAST

Pain in breast.....☐
Nipple discharge.....☐
Breast lumps.....☐

SKIN INTEGUMENTARY

Rash or ulcers.....☐

NEUROLOGICAL

Dizziness.....☐
Seizures.....☐
Numbness.....☐
Trouble walking.....☐

PSYCHIATRIC

Depressed mood, sadness.....☐
Inability to concentrate.....☐
Problems sleeping.....☐
Anxiety.....☐
Change in appetite.....☐
Feeling helpless, worthless.....☐

ENDOCRINE

Dry Skin.....☐
Abnormal thirst.....☐
Hot flashes.....☐

HEMATOLOGIC/LYMPHATIC

Bruises, frequent.....☐
Cuts do not stop bleeding.....☐
Enlarged lymph nodes.....☐

INSURANCE

Do you have any insurance changes? NO _____ YES _____ PLEASE LIST NEW INFORMATION BELOW:

Insurance Company: _____ Contract#: _____ Group#: _____

Policyholder's Name: _____ DOB: _____ Relationship to Patient: _____

SIGNATURE: _____ DATE: _____

BROOKWOOD WOMEN'S HEALTH, P.C.

Non-Covered Services Waiver

As your physicians, we want to provide you with the best care possible. There are services that we feel are necessary for the maintenance of good health and/or treatment of your condition that may not be covered by your health insurance. If they are non-covered, you will be expected to pay for those services. We will order only the tests and/or treatments that we feel are necessary for your treatment and care. If you have questions about whether or not a particular service is covered, our staff will be glad to assist you. However, we do not guarantee payment of your claim. Final determination of payment will be made by your insurance company when they receive our claim.

Bioidentical Hormone Implant:

Routine services-Pre-existing conditions

Mental/Nervous/Anxiety conditions: Labs:

DX screening (DEXA)/(Ultrasound): Injections

Contraceptive devices: Weight Management:

Service(s) that may not be covered

Date

Patient Signature