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

LAST NAME _____ **FIRST NAME** _____

Have you ever received a dose of COVID-19 Vaccine? ☐ **YES** ☐ **NO**

☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another Product _____

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

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, out 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. No Show Fee - We understand that situations arise in which you must cancel your appointment. It is therefore requested that you provide a 24 hour notice. Appointments which are not cancelled may be subject to a $30.00 fee, per occurrence, that is not covered by insurance.

_____ _____

Date **Patient Signature**