Brookwood
Women's Health, P.C.

ACCT#_____

WT: _____

BP:_____

OFFICE USE ONLY

TODAYS DATE _____

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

LAST NAME _____ **FIRST NAME** _____

Have you ever received a dose 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 NAME(S) _____ **No**

Do you have a primary care doctor? Yes/Name_____ No

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

Last Pap/Annual _____

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 ☐

OVER

Brookwood Women's Health: Medical History Form (NEW)

Name:_____ **Date** _____/ _____/ _____

Medical History: (list any medical problems: diabetes, asthma, migraines, hypertension, depression, etc.)

_____

_____

Pregnancy History: (any pregnancies you have had)

Date of Delivery	How many weeks?	Birth Weight	Male or Female?	Cesarean, Vaginal	Reason for Cesarean?	Epidural?	Place of Delivery	Complications/Comments?

Any miscarriages / abortions? ____ If yes, how many? _____ Procedure or medication?_____

GYN:

Age at onset of first period _____ How many days apart are your periods? _____

How many days does your period last? _____ Would you consider them heavy? _____

Do you have pain with periods? _____ Do you take medication for this? _____ If so, what medication? _____

Have you had: Endometriosis? _____ An abnormal pap smear? _____ Sexually transmitted infection? _____

Are you sexually active?_____

Surgical History: (list any surgeries/hospitalizations and dates they were performed)

_____

_____

Social History:

What is your marital status? Single Engaged Married Common Law Divorced Separated Widowed Other

What is your occupation? _____

Family History:

Relationship	Breast, Ovarian, Uterine or Colon Cancer (Specify)	Blood Clots	Diabetes	Heart Disease (Heart attack)	Hypertension	High Cholesterol	Other
Mother							
Father							
Brother							
Sister							
Maternal GF							
Paternal GF							
Maternal GM							
Paternal GM							