Brookwood Women's Health, P.C.

ACCT# _____
BP: _____
Ht: _____
Wt: _____

Please circle the provider you are here to see:

DEISHER FALKENSTROM FREEMAN HULKER MORGAN PATTERSON STRAUGHN

LAST NAME: _____FIRST NAME: _____DOB: _____

Marital Status: S M D W O Patient's Employer: _____Position: _____

Pharmacy Name & Address: _____

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

_____

Are you allergic to any medications? Yes___ No__ If so, list and name reaction: _____

Please list all the medications and dosages you are currently taking, including prescription & over the counter:

_____

_____

Gynecology History: When was the FIRST day of your last menstrual cycle? _____

Are you sexually active? Yes ___ No___ Sexual Preference?_____

Have you had a sexually transmitted infection? Yes ___ No __

What are you using for contraception? Birth Control Pills The Patch The Ring Depo-Provera Nexplanon IUD Condoms Pullout Natural Family Planning Tubal Vasectomy Nothing

Last Pap/Annual: _____Last Mammogram: _____ Last Colonoscopy: _____ Last Bone Scan: _____

Have you ever received a dose of the HPV vaccine? Yes___ No___

Family History: Please list any NEW or CHANGES to your family history since your last office visit:

_____

Social History: Do you exercise? If yes, how frequently? _____

Do you smoke? If yes, how much per day? _____

Do you drink alcohol? If yes, how much? _____

Do you use recreational drugs? _____

Surgical History: Please list any NEW surgical procedures/hospitalizations and date performed since your last visit?

_____

Medical History: Please list any NEW medical problems since your last office visit:

_____

Patient Signature: _____ Date: _____ Annual