Brookwood Women's Health, P.C.

ACCT # _____
BP _____
Height _____
Weight _____

Postpartum/PostOp Form

Provider you are here to see:

❍ Deisher ❍ Falkenstrom ❍ Freeman ❍ Hulker ❍ Morgan ❍ Patterson ❍ Straughn

Last Name_____ First Name_____

Date of Birth _____

Pharmacy Name & Address _____

_____

Who is your Primary Care Provider?_____

What is the purpose of your visit? ❍ Postpartum ❍ PostOp

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

_____

Are you allergic to any medications? ❍ Yes ❍ No If yes, list and name reaction _____

_____

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

_____

_____

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 visit _____

_____

POSTPARTUM PATIENTS ONLY

Are you breastfeeding/pumping? ❍ Yes ❍ No Are you using formula? ❍ Yes ❍ No

What type of delivery did you have? ❍ Vaginal ❍ Cesarean ❍ VBAC

Have you stopped bleeding since your delivery? ❍ Yes ❍ No Have you had a period since delivery? ❍ Yes ❍ No

Would you like to discuss birth control today? ❍ Yes ❍ No Have you had intercourse since delivery? ❍ Yes ❍ No

Patient Signature:_____ Date _____ PO/PP