Women's Health brazosport

NAME: **DOB:** **DATE:**

ARE YOU HERE TODAY FOR A:

- ❑ **ROUTINE ANNUAL EXAM**
- ❑ **PROBLEM** _____

PREFERRED PHARMACY:		
MEDICATIONS (INCLUDE OVER THE COUNTER) (DRUG NAME/DOSAGE)		
DRUG ALLERGIES:		
MEDICAL HISTORY		
❑ DIABETES ❑ HIGH CHOLESTEROL ❑ HYPERTENSION ❑ HYPERTHYROIDISM ❑ HYPOTHYROIDISM ❑ ANXIETY ❑ DEPRESSION ❑ HEARTBURN ❑ CROHN'S DISEASE ❑ LUPUS ❑ OVARIAN MASS	❑ OVARIAN CYST ❑ ENDOMETRIOSIS ❑ FIBROMYALGIA ❑ RHEUMATOID ARTHRITIS ❑ ATRIAL FIBRILLATION ❑ ABNORMAL HEART BEAT ❑ HEART ATTACK ❑ CORONARY ARTERY DISEASE ❑ STROKE	❑ GALLSTONES ❑ GOITER ❑ BREAST CANCER ❑ OVARIAN CANCER ❑ CERVICAL CANCER ❑ COLON CANCER ❑ UTERINE CANCER ❑ ENDOMETRIAL CANCER ❑ _____ _____
SURGICAL HISTORY ***(procedure/year)***		

FAMILY HISTORY **(circle which one applies) (Please write which family member/ age of diagnosis ex: maternal grandpa, 55)**	
Breast cancer	
Uterine cancer	
Colon Cancer	
Ovarian Cancer	
Diabetes	
Stroke	
Deep Vein Thrombosis (DVT)	
Hypertension	
Other family history	

GYNECOLOGICAL HISTORY		
Currently Sexually Active? Yes / No	Pain with intercourse? Yes / No	Sexual orientation:
Last Pap Smear (Mth/Yr):	Abnormal pap in past: Yes / No	If yes, when?
Last Mammogram (Mth/Yr):	Abnormal Mammo/Breast Biopsies: Yes / No	If yes, when?
Last colonoscopy (Mth/Yr):	Result:	
Last Bone Density (Mth/Yr):	Result:	
Current vaccinations: ❑ Flu ❑ Pnemonia ❑ Shingles ❑ Tetanus ❑ Gardasil	History of STD's: (circle all that apply) Gonorrhea Syphilis Chlamydia Genital Warts Trichomonas HIV Herpes (HSV) HPV	Age periods began: Frequency of periods: # of days bleeding:
Are you currently pregnant? Yes / No	Last menstrual period:	Pain with periods? Yes / No

History of Sexual abuse: Yes / No	Recent changes in periods? Yes / No If yes, what?	
OBSTETRIC HISTORY		
Total Pregnancies:	Living children:	Full Term: Preterm:
Abortions: Miscarriages:	Cesarean sections:	Vaginal deliveries:
Circle your form(s) of birth control: Fertility based method / Withdrawal / Condoms / Spermicide / Pills / IUD / Implant / Ring / Patch / Shot / Emergency contraception / Essure / Tubal / Vasectomy / Hysterectomy		
SOCIAL HISTORY		
Tobacco use: Yes / No How Long? How many daily? Ready to quit? Yes / No		
Alcohol use: Yes / No How often? How many?		**Illegal Drug use:** Yes / No
Have you traveled outside the U.S. in the past 3 months? Yes / No If yes, where?		

BRAZOSPORT WOMEN'S HEALTH

TODAY'S DATE_____/_____/_____

LAST NAME_____ **FIRST NAME** _____ **MI** _____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP CODE**_____

SEX (*CIRCLE ONE*) Male — Female **SSN**_____-_____-_____ **DATE OF BIRTH**_____/_____/_____

HOME PHONE (_____) _____-_____ **CELL** (_____) _____-_____ **WORK** (_____) _____-_____

EMAIL ADDRESS_____

MARITAL STATUS (*CIRCLE ONE*) Single / Married / Divorced / Separated / Widowed / Partner

PRIMARY CARE AND/OR REFERRING PHYSICIAN_____

EMERGENCY CONTACT_____ **RELATIONSHIP**_____ **PHONE**_____

EMPLOYER OF PATIENT OR GUARANTOR_____

INFORMATION RELEASE: [Health information collected here about me may be disclosed to the following persons.]

NAME_____ **RELATION**_____

NAME_____ **RELATION**_____

IF THE PATIENT IS UNDER THE AGE OF 18:

RESPONSIBLE PARTY_____ **RELATIONSHIP**_____ **PHONE**_____

PLEASE TELL US HOW YOU HEARD ABOUT US: _____

I request that payment of authorized Medicare/Insurance benefits be made on my behalf to the above named doctor/group for any services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services. I hereby assign benefits to the doctor or group indicated on this claim. I understand that I am responsible for the co-pay at time of visit. Having insurance is not a substitute for payment. I further understand that if my benefits are not verifiable, I might be responsible for charges in full with a possible reimbursement after verification is obtained. A copy of this signature is as valid as the original. I also acknowledge I am responsible for any fraudulent information I provide to this office or in accordance with my benefits.

By signing this I also acknowledge that I have read and understand Brazosport Women's Health's Notice of Privacy Practices. A copy is located in the lobby and will be given to a patient upon request. I authorize the person(s) listed above to receive all health information about appointments, treatments and/or other information pertinent to my health care provided by Brazosport Women's Health.

We emphasize that as a medical care provider, our relationship is with you and not your insurance company. We cannot be responsible for any loss of benefits. If you have any questions concerning the above information, please do not hesitate to ask us. We are here to help you.

If you would like your labs processed somewhere specific, you need to specify this in writing. We will provide a form upon request and will do our best to make sure this happens.

If you do not show up for your appointment without 24-hour advance notice cancelling, you will be charged up to $250. This is done in order to preserve the schedule. Thank you.

Signature of Patient or Guarantor_____ **Date**_____

Women's Health
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Name: _____ Email: _____

Review of Systems

General/Constitutional

Weight gain	O Yes	O No
Weight loss	O Yes	O No
Fever	O Yes	O No
Sleep disturbance	O Yes	O No
Fatigue	O Yes	O No

Endocrine

Hot flashes	O Yes	O No
Cold intolerance	O Yes	O No
Excessive facial hair	O Yes	O No

Breast

Breast pain	O Yes	O No
Nipple discharge	O Yes	O No
Palpable lump	O Yes	O No

Hematology

Easy bruising	O Yes	O No
Prolonged bleeding	O Yes	O No
H/o blood clots	O Yes	O No

Neurologic

Headache	O Yes	O No
Seizures	O Yes	O No
Memory loss	O Yes	O No
Weakness	O Yes	O No

Respiratory

Cough	O Yes	O No
Sore throat	O Yes	O No
Shortness of breath	O Yes	O No

Gastrointestinal

Abdominal pain	O Yes	O No
Nausea	O Yes	O No
Vomiting	O Yes	O No
Blood in stool	O Yes	O No
Constipation	O Yes	O No
Diarrhea	O Yes	O No

Cardiovascular

Chest pain	O Yes	O No
Palpitations	O Yes	O No
Dizziness	O Yes	O No
Swelling in hands/feet	O Yes	O No

Psychiatric

Depressed mood	O Yes	O No
Anxiety	O Yes	O No
Mood changes	O Yes	O No

Genitourinary

Blood in urine	O Yes	O No
Burning sensation	O Yes	O No
Difficulty urinating	O Yes	O No
Frequent urination	O Yes	O No
Painful urination	O Yes	O No
Urine leakage	O Yes	O No

Musculoskeletal

Recent fracture	O Yes	O No
Muscle aches	O Yes	O No
Joint swelling	O Yes	O No
Back pain	O Yes	O No
Joint pains	O Yes	O No