

**Augusta Health Care for Women
Intake Form**

Appointment Date: _____ **Chart #** _____

Legal Name: _____ **Date of Birth** _____

Name you prefer us to use: _____ **Primary Care Physician** _____

Reason for today's visit or special concerns: _____

Date last period ___/___/___ **Are your periods (circle) Normal Irregular Heavy Painful**

Age at 1st period _____ **Usual # of days between period** _____ **Usual # of days of flow** _____

Current Method of Birth Control (if needed) _____

Total # of pregnancies _____ **# of children living** _____ **Miscarriages** _____

Allergies _____

Medications and dosages (including OTC & Herbal) _____

Have you had any of the following medical problems? (Circle)

High blood pressure	Cancer	Migraines	Urinary Infections
Heart problems/Murmurs	Phlebitis (blood clots)	Depression	Hepatitis
Diabetes	Asthma/lung disorder	Seizures	Ulcers/Reflux
High Cholesterol	Thyroid Problems	HIV/AIDS	
Abnormal Pap Smear	Sexually transmitted disease		
Other: _____			

List all of your previous surgery and approximate date or age:

Do you smoke? _____ **Packs/day** _____ **Do you drink alcohol?** _____ **drinks/week** _____

Do you exercise on a regular basis? _____ **Do you routinely use a seat belt?** _____

Do you now or have you ever felt unsafe in a relationship? _____

Please answer questions on next/back of this page

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Family History – Have any of your blood relatives had the following? (circle and list relative)

Breast Cancer _____	Heart Disease _____
Colon Cancer _____	High Blood Pressure _____
Uterine/Ovarian Cancer _____	Stroke _____
Other Cancer _____	Osteoporosis _____
Diabetes _____	Other _____

Have you experienced any of the following symptoms in the past 6-12 months?

Yes	No		Yes	No	
___	___	Weight gain/loss	___	___	Blood in the stool
___	___	Severe headaches/migraines	___	___	Skin rashes/sores
___	___	Change in vision or hearing	___	___	Change in mole(s)
___	___	Numbness or weakness	___	___	Painful urination
___	___	Depression/Anxiety	___	___	Blood in urine
___	___	Aches or swelling in joints	___	___	Uncontrolled loss of urine
___	___	Chest pain/irregular heartbeat	___	___	Abnormal vaginal discharge
___	___	Shortness of breath	___	___	Sores on genital area
___	___	Chronic cough	___	___	Painful intercourse
___	___	Abdominal pain	___	___	Loss of sexual desire
___	___	Frequent constipation or diarrhea	___	___	Breast lumps/nipple discharge
___	___	Fever	___	___	Swollen Lymph Glands

Children’s names and dates of birth (if previously filled out, you may skip this):

01/2011