

## *Augusta Health Care for Women Intake Form (Interim)*

Appointment Date: \_\_\_\_\_ Chart # \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Reason for today's visit: Please describe your symptoms and duration: \_\_\_\_\_

Date last period \_\_\_/\_\_\_/\_\_\_ Are your periods (circle) Normal Irregular Heavy Painful

Current Method of Birth Control (if needed) \_\_\_\_\_

Allergies \_\_\_\_\_

Medications and dosages (including OTC & Herbal) \_\_\_\_\_

Surgeries or Procedures in the past 12 months: \_\_\_\_\_

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

High blood pressure	Cancer	Migraines	Urinary Infections
Heart problems/Murmurs	Blood Clots	Depression	Hepatitis
Diabetes	Asthma/lung disorder	Seizures	Ulcers/Reflux
Abnormal Pap smear	Sexually transmitted disease	Thyroid Problems	
High Cholesterol	Other: _____		

Do you drink alcoholic beverages? \_\_\_\_\_ Type/how much/how often: \_\_\_\_\_

Do you use recreational drugs or non-prescribed narcotics (Marijuana, Vicodin, Percocet, etc )? \_\_\_\_\_

Do you use tobacco products? \_\_\_\_\_ Type/how much/how often: \_\_\_\_\_

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
___	___	Swollen lymph nodes	___	___	Fevers
___	___	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