Patient Intake Form

Obstetrics & Gynecology Associates of Augusta, P.C.
1430 Harper Street, Building A
Augusta, Georgia 30901
www.ogaaugusta.com

Today's date _____ / _____ / 20 _____

Please print legibly.

Please complete this form:

- Bring form to your appointment or,
- Mail form in the enclosed envelope* or,
- Fax to (706) 724-2523*

*at least one day before your appointment

Name: _____
(First) (Middle) (Last)

Mail address: _____
(Street or post office box) (City) (State) (Zip)

Birth date: _____ Social security number: _____

Home phone: ( ) _____ - _____

Work phone: ( ) _____ - _____

Cell phone: ( ) _____ - _____

E-mail: _____

Primary physician: _____ Primary physician partner(s) name (if known): _____

Reason for visit today: □ Routine Annual □ OB care □ Problem - please describe: _____

Please check (below) if you have had any of the following medical problems in the past.

Past Medical History	**Yes**	**No**		**Yes**	**No**
Gynecologic			Other (injury/poisonings):		
Fibroid tumors			**Musculoskeletal**		
Endometriosis			Arthritis		
Ovarian cysts			Rheumatoid arthritis		
Sexually transmitted diseases (STDs)			Systemic lupus		
Cancer/Precancer Cervix			Osteoporosis		
Other:			Other:		
Breast			**Cancer of …**		
Breast cancer			Ovary		
Fibrocystic breast disease			Uterus		
Breast lumps			Skin		
Other:			Colon		
Cardiovascular			Other:		
Hypertension			**Neurologic**		
Heart attack			Seizures		
High cholesterol			Migraines		
Mitral valve prolapse			Strokes		
Other:			Other:		
Digestive			**Psychiatric**		
Stomach ulcer			Depression		
Colitis			Anxiety disorder		
Reflux disease			Schizophrenia		
Hepatitis			Other:		
Other:			**Respiratory**		
Endocrine			Emphysema COPD		
Diabetes			Asthma		
Thyroid problems			Other:		
Other:			**Dexa/Mamm/Pap** (please give date)		
Hematologic			Dexascan:		
Anemia			Mammogram:		
Sickle cell			Pap smear:		
Clots in legs or pelvis			**Urologic**		
Von Willebrand Disease			Kidney stones		
Factor V Leiden			Incontinence		
Pulmonary embolism			Other:		
Other:			**Other**		
Injury/Poisonings					
Motor vehicle accident					
Pelvic fractures					
Hip factures					

Please list (below) any prior surgeries you have had.

Surgery/Reason	**Date**	**Surgery/Reason** (cont'd)	**Date**

Please list (below) medications that you are currently taking.

Drug name	Dosage	Physician	**Drug name** (cont'd)	Dosage	Physician

Please list known allergies to medication or substances (e.g. latex, iodine, etc.):

Circle and check (below) if your blood relatives have had any of the following:

Family History	Yes	No	Relative	**History** (cont'd)	Yes	No	Relative	**History** (cont'd)	Yes	No	Relative
Gynecologic				**Neurologic**				**Psychiatric**			
Endometriosis				Stroke				Depression			
Fibroids				**Respiratory**				**Gastroenterology**			
Cancer-Uterus				Cancer-Lung				Cancer-Colon			
Cancer-Ovary				**Hematologic**				**Breast**			
Cardiovascular				Sickle Cell				Cancer-Breast			
Hypertension				Leukemia				**Other:**			
Heart attack				Clots in legs							
				Bleeding disorder							

If you are pregnant, please circle and check if you, the father of the baby, or any blood relatives have the following:

Genetic screening	Yes	No		Yes	No
Cystic Fibrosis			Patient or father of baby w/birth defects not listed		
Down Syndrome, mental retardation, autism, Fragile X			Recurrent pregnancy loss/stillbirth		
Heart defects at birth			Sickle Cell Disease or trait		
Hemophilia			Tay-Sachs Disease (Jewish, Cajun, French Canadian)		
Huntington Chorea			Thallasemia (Italian, Greek, Mediterranean, Asian)		
Maternal metabolic disorder (Diabetes, PKU)			Canavan's Disease		
Muscular Dystrophy			Other inherited genetic/chromosomal disorders:		

Reproduction/Menstrual history

Age of first period: _____ Cycle interval: _____ Periods last how many days? _____ Your last menstrual date: _____

Menopausal (circle one): Yes / No Birth control method: _____

Obstetric history

Total pregnancies: _____ Premature delivery (less than 37 weeks): _____ Miscarriages: _____ Full term births (more than 37 weeks): _____

Abortions/Elective terminations: _____ Living children: _____

On the chart below, please fill in information for each pregnancy including abortions or miscarriages.

Number	**Birthdate**	**Weeks gestational age**	**Sex**	**Weight**	**Delivery** (vaginal or C-Section?)	**Complications**
1						
2						
3						
4						
5						
6						
7						
8						

Social history

Please circle one of each below or complete where necessary:

Single / Married Sexually active: Yes / No Do you smoke? Yes / No If yes, number of cigarettes per day: _____ How long have you smoked? _____

Alcohol use: Yes / No Describe number of drinks and type of drinks per week: _____