# Alexandria Women's Center Intake Form

**Patient Name:** _____ **Address:** _____

**Date of Birth:** _____ _____

**Contact number:** _____ **Work contact:** _____

**Contact email:** _____ **Spouse/Partner:** _____

**Referred by:** _____ **Employer:** _____

**Insured by:** _____ **Today's Date:** _____

## Review of Systems: Do you currently suffer from any of the symptoms below?

| | | | | | |
|---|---|---|---|---|---|
| **Head/Neck** | Changes in vision | Yes☐ No☐ | **Respiratory** | Fever | Yes☐ No☐ |
| | Migraine headaches | Yes☐ No☐ | | Cough | Yes☐ No☐ |
| | Seizures | Yes☐ No☐ | | Asthma symptoms | Yes☐ No☐ |
| | Dizziness | Yes☐ No☐ | | Seasonal allergies | Yes☐ No☐ |
| **Cardiovascular** | Chest pain | Yes☐ No☐ | **Gastrointestinal** | Diarrhea | Yes☐ No☐ |
| | Shortness of breath | Yes☐ No☐ | | Constipation | Yes☐ No☐ |
| | Unable to sleep flat | Yes☐ No☐ | | Blood in stools | Yes☐No☐ |
| | Irregular heart beat | Yes☐ No☐ | | Darker stools | Yes☐No☐ |
| | Frequent loss of consciousness | Yes☐ No☐ | | Abdominal Pain | Yes☐No☐ |
| | Blood clots in legs, lungs, brain | Yes☐No☐ | | Nausea or Vomiting | Yes☐No☐ |
| **Breast** | Breast pain | Yes☐No☐ | **Urologic** | Burning with urination | Yes☐ No☐ |
| | Leaking from the nipples | Yes☐ No☐ | | Urinating too often | Yes☐ No☐ |
| | Lumps in breast | Yes☐ No☐ | | Leaking urine with cough or sneeze | Yes☐ No☐ |
| **Gynecology** | Heavy periods | Yes☐No☐ | Daily pelvic pain | | Yes☐No☐ |
| | Periods happen every month | Yes☐ No☐ | Hot flashes/Night sweats | | Yes☐No☐ |
| | Irregular periods | Yes☐ No☐ | Painful intercourse | | Yes☐No☐ |
| | Periods are too long | Yes☐ No☐ | Vaginal discharge | | Yes☐No☐ |
| | Periods are too short | Yes☐ No☐ | Vaginal dryness | | Yes☐No☐ |
| | Periods are too light | Yes☐ No☐ | Unprotected sexual encounter | | Yes☐No☐ |
| | Painful periods | Yes☐ No☐ | Unwanted sexual encounter | | Yes☐No☐ |
| **Endocrine** | Acne | Yes☐ No☐ | **Psychiatric** | Anxiety | Yes☐ No☐ |
| | Unwanted hair growth | Yes☐No☐ | | Depression | Yes☐ No☐ |
| | Increased weight in waist | Yes☐No☐ | | Mood swings | Yes☐No☐ |
| | Waking at night to urinate | Yes☐No☐ | | Racing thoughts | Yes☐ No☐ |
| | Feeling cold when others are normal | Yes☐No☐ | | Feeling out of control | Yes☐ No☐ |
| | Weight loss | Yes☐No☐ | | Excessive anger | Yes☐ No☐ |
| | Weight gain | Yes☐No☐ | | Suicidal thoughts | Yes☐ No☐ |
| | Fatigue | Yes☐No☐ | | Domestic abuse | Yes☐ No☐ |

## Past Medical History: Do you suffer from any of the medical conditions below?

| | | | |
|---|---|---|---|
| High blood pressure Yes☐No☐ | Diabetes Yes☐No☐ | Stroke Yes☐No☐ | Heart disease Yes☐No☐ |
| Obesity Yes☐No☐ | Asthma Yes☐No☐ | Lupus Yes☐No☐ | Chrons/Ulcerative colitis Y☐N☐ |
| Cancer Yes☐No☐<br>Explain_____ | Blood clots Yes☐No☐ | Migraine headaches Yes☐No☐ | Seizure disorder Yes☐No☐ |
| Stomach Ulcers Yes☐No☐ | Kidney failure Y☐N☐ | Kidney stones Yes☐No☐ | Frequent UTI Yes☐No☐ |
| Anemia/Transfusions Yes☐No☐ | Hypothyroid Y☐N☐ | Hyperthyroid Yes☐No☐ | Other: |

**Past Surgical History: Please check off your prior surgeries.**

| | |
|---|---|
| Gallbladder removal ☐ | C-section ☐ |
| Weight loss surgery ☐ | Hernia repair ☐ |
| D&C ☐ | Surgery to correct abnormal pap smear ☐ |
| Hysterectomy ☐ | Endometriosis ablation ☐ |
| Removal of **one** ovary ☐ | Removal of **both** ovaries ☐ |
| Breast enhancement ☐ | Breast reduction ☐ |
| Tonsillectomy ☐ | Removal of appendix ☐ |
| Tubal ligation ☐ | Ablation of the uterine lining ☐ |
| Removal of fibroids leaving uterus in place ☐ | Removal of kidney stones ☐ |
| Laparoscopy ☐ | Bladder suspension ☐ |
| Removal of uterine polyp ☐ | Urethral sling ☐ |
| Other: | Other: |
| Other: | Other: |

**Past Gynecologic History: Please check off any prior conditions.**

| | | |
|---|---|---|
| Endometriosis ☐ | Fibroids ☐ | Abnormal pap smear ☐ |
| Ovarian cyst ☐ | Polycystic ovarian syndrome ☐ | Frequent bacterial vaginosis ☐ |
| Frequent yeast infections ☐ | Herpes ☐ | Gonorrhea ☐ |
| Chlamydia ☐ | Syphilis ☐ | HIV ☐ |
| Hepatitis ☐ | HPV ☐ | Trichomonas ☐ |
| Infertility ☐ | Lichen sclerosis ☐ | Other: |

**Past Obstetrical History: Please list ALL pregnancies by year occurred and include miscarriages/terminations.**

| Year | Type of delivery | Miscarriage | Weeks | Birth weight | Gender | Complications |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Past Family History: Please check off any known family conditions.**

| | | | |
|---|---|---|---|
| Diabetes Yes☐No☐ | Hypertension Y☐N☐ | Stroke Yes☐No☐ | Heart disease Yes☐No☐ |
| Breast cancer Yes☐No☐ | Ovarian cancer Y☐N☐ | Uterine cancer Y☐N☐ | Thyroid disease Yes☐No☐ |
| Other: | Other: | Other: | Other: |
| Other: | Other: | Other: | Other: |

**Social History: Please complete. If your answer is N, you may move to the next question.**

| | | | |
|---|---|---|---|
| Do you smoke tobacco? Yes☐ No☐ | Do you drink alcohol? Yes☐ No☐ | Do you use recreational drugs? Yes☐ No☐ | Do you wear your seatbelt regularly? Y☐ N☐ |
| # Packs cigarettes/day ____ | # drinks/week _____ | If yes: which drugs? | Is your home safe? Yes☐ No☐ |
| # years smoking ____ | Do your loved ones have a problem with your drinking? Yes☐ No☐ | | |

**Please select appropriate answer:**

Are you? Single☐ Married☐ Widowed☐ Divorced☐

What is your profession? _____

**Allergies: Do you have any known DRUG allergies to medications?** Yes☐ No☐

| Drug Allergy | Reaction |
|---|---|
| | |
| | |
| | |

**Medications: Please list ALL current medications and dosages.**

| Medication | Dosage | Instructions (example: 1 tab daily) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Immunizations: Please indicate when your last immunization took place.**

| **Vaccination** | **Last year received** |
|---|---|
| Flu | |
| COVID | |
| Pnuemonia | |
| Guardisil | |
| Tetanus | |

**Patient Signature: _____ Date: _____**

**AWC Staff Signature: _____ Date: _____**