the memorial hospital at craig

TMH OB/GYN CLINIC
785 Russell Street, Craig, CO 81625
970-826-2420 (Phone) 970-826-2439 (Fax)

Final EDD:

Today's Date:_____

OB PATIENT HISTORY

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor of nurse.

Name	Birthdate	Age
Spouse/Partner Name	Father of Baby	
Spouses Day Phone	Is Father Involved	
Emergency Contact Person/Relationship		
Newborn's Physician		
Preferred Pharmacy	Pharmacy Phone Number	

MENSTRUAL HISTORY

First Day of Last Menstrual	Definite Approximate Unknown
Age Periods Began	# of Days of Bleeding w/Period
# of Days Between Periods	Menses Monthy (Yes or No)
Symptoms Since Last Menstrual Period	Date of Positive Pregnancy Test

OBSTETRIC HISTORY

Number of Pregnancies (include this one)	Number of Miscarriages
Number of Live Births	Number of Abortions
Number of Living Children	Number of Premature Births (<37 weeks)

PATIENT INTAKE HISTORY - 2

Past Pregnancies (Last Six)

No.	Birth Date	Birth Weight	Sex M/F	Weeks Pregnant	Type of Delivery	Any Complications/Comments
1						
2						
3						
4						
5						
6						

YOUR MEDICAL HISTORY

If any of the following apply to your or your immediate family, please mark yes and give details in the space provided.

	Yes/No	Details Yes Remarks; include date(s) and treatment	
Diabetes			
Hypertension			
Heart Disease			
Autoimmune Disorder			
Kidney Disease/UTI			
Neurologic/Epilepsy			
Psychiatric			
Depression/Postpartum Depression			
Hepatisis/Liver Disease			
Varicosities/Phlebitis			
Thyriod Dysfunction			
Trauma/Violence			
History of Blood Transfusion			
D (Rh) Sensitized			
Pulmonary (TB Asthma)			
Seasonal Allergies			
Drug/Latex Allergies/Reactions			
Breast			
GYN Surgery			
Operations/Hospitalization (Year/Reason)			
Anesthetic Complications			
History of Abnormal Pap			
Uterine Anomaly/DES			
Uinfertility			
Relevant Family History			
Other			
	Amt/Day PrePreg	Amt/Day Pregnant	# Years Use
Tobacco			
Alcohol			
Illicit/Recreational Drugs			

PATIENT INTAKE HISTORY - 3

Genetic Screening / Teratology Counseling

	Yes or No	Detail Yes Remarks; Include date(s) and treatment.
Will Patients Age be over 35 at time of Delivery?		
Thalassema(Italian, Greek, Mediterranean, Asian Background) MCV<80		
Neural Tube Defect		
Congenital Heart Defect		
Down Syndrome		
Tay-Sachs (eg. Jewish, Cajun, French, Canadian)		
Canavan Disease		
Sickle Cell Disease of Trait (African)		
Hemophilia or other Blood Disorders		
Muscular Dystrophy		
Cysitic Fibrosis		
Huntingtin's Chorea		
Mental Retardation/Autism, if yes was person tested for Fragile X?		
Other Inherited Genetic or Chromosonal Disorder		
Material Metabolic Disorder (ie. Type I Diabetes, PKU)		
Patient or Baby's Father had a child with Birth Defects not Listed Above		
Recurrent Pregnancy Loss or Stillbirth		
Medications Used (including supplements, vitamins, herbs or over the counter drugs) Illicit/Recreational Drugs/Alcohol since last menstrual period.		
Any Other		
Comments/Counseling		
Infection History:	**Yes or No**	
Live With Someone With TB or Exposed to TB		
Patient or Partner has History of Genital Herpes		
Rash or Viral Illness Since Last Menstrual Period		
History of STD, Gonorrhea, Chlamydia, HPV, Syphilis		
Other		
Comments		**Interviewer's Signature:**