the memorial hospital at craig

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

Today's Date:_____

PATIENT INTAKE HISTORY

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

Name / Daytime Phone Number	Birthdate
Spouse/Partner Name	Did you sign the HIPAA form for us to release info. To your spouse/partner?
Pharmacy Name and Phone Number	Do you have any Allergies
What is the Reason for Your Visit?	
Please Describe any problem you may be having today (if applicable)	

GYNECOLOGIC HISTORY

How old were you when you began having a period?	First day of last normal menstrual period? How many days did it last?
How many days do you have between periods?	Have you experienced and recent changes in your periods?
Have you ever used an IUD or birth control pills? If yes, for how long?	Do you have any abnormal bleeding?
When was your last PAP test?	What was the result of your last PAP test?
Have you ever had an abnormal PAP test?	Do you do regular breast self-examinations?

PATIENT INTAKE HISTORY

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OBSTETRIC HISTORY

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

NO	Birthdate	Weight @ Birth	Sex of Baby	Week Pregnant	Type of Delivery	Complications
1			M F		VAG C-SECT	
2			M F		VAG C-SECT	
3			M F		VAG C-SECT	
4			M F		VAG C-SECT	

PHYSICIAN NOTES ON OB HISTORY:

CURRENT MEDICATIONS/CHEMICALS
(Including hormones, vitamins, herbs, non-prescriptive medications)

Drug Name	Dosage - Who Prescribed	Drug Name	Dosage - Who Prescribed

Ever Smoked ? Yes No Current Smoker? Yes No If yes, how many packs a day?

Years Smoked:

Alcohol: Number of drinks per day _____ Number of drinks per week _____

Recreational Drug Use? Yes No If yes, describe type, frequency, etc.

PATIENT INTAKE HISTORY

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OPERATIONS/HOSPITALIZATIONS

Reason	Date	Hospital

SERIOUS INJURIES/ILLNESSES

Type	Date
Type	Date
Type	Date
Type	Date

IMMEDIATE FAMILY MEDICAL HISTORY

Illness	Self - Yes	Which Relative(s) & Age of Onset	Physician Notes
Diabetes			
Stroke			
Heart Disease			
Blood Clots (Lungs or Legs)			
High Blood Pressure			
High Cholesterol			
Osterporosis			
Hepatitis			
HIV/AIDS			
Tuberculosis			
Birth Defects			
Drinking/Drugs			
Breast Cancer			
Colon Cancer			
Ovarian Cancer			
Uterine Cancer			
Mental Illness			
Depression			