Terrell OB-GYN Clinic

Marie Hollis, M.D.
Kim Parks, CNM-Heather Kent, CNM
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109 Tejas Drive, Suite 100
Terrell, TX 75160
Phone: 972-563-3334 Fax: 972-563-3339

Patient Intake Information/Infomacion de Paciente

Name: _____
First (Nombre de Pila) **MI** **Last (Apellido)**

SS#: _____ **DOB:** _____

Address/Dirección: _____ **City:** _____ **ZIP Code:** _____

Home phone: _____ **Cell #** _____ **Work#** _____

Email _____ **Marital Status:** _____
(Correro Electonico) **(Estado Civil)**

Race: _____ **Ethnicity** _____ **Preferred Language** _____
(Carrera) **(Etnicida)** **(Idioma)**

Employer _____ **Occupation** _____
(Lugar de empleo) **(Ocupación)**

Emerg. Contact _____ **Phone** _____
(Contacto de emergencia) **(Teléfono)**
Emrg. Contact Relationship to patient _____ **(relacion a paciente)**

Spouse _____ **DOB:** _____ **Phone** _____
(Esposa) **(Teléfono)**

Preferred Pharmacy: _____

Insurance Information

Ins. Company _____ **(Compañía de seguro)**

Policy # _____ **Group#** _____
(Política) **(Grupo)**
Name of Insured _____
(Nombre de asegurado)

Insured's DOB _____ **Relationship** _____
(Fecha de nacimiento del asegurado) **(Relacion del asegurado al paciente)**
Employer: _____
(Lugar de empleo)

Secondary

Ins. Company/ _____ **Policy #** _____
Group#/Grupo: _____
Name of Insured/Nombre de asegurado: _____
Insured's DOB/Fecha de nacimiento del asegurado: _____ **Relationship/Relacion del asegurado al paciente:** _____
Employer/Lugar de empleo : _____

Patient Name: _____ Date of Birth _____

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Reason for Visit

What brings you in today, and/or what concerns do you have?

_____
_____
_____
_____
_____
_____

Current Medications and/or over the counter medication along with any vitamins you may be taking: If you do not have enough space below please list on back of page.

Name	**Dose**	**How it is taken**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to anything? ☐ **Yes** ☐ **No**

If yes, list all things allergic to below. If not enough room please list on back of page.

Name	**Reaction**
_____	_____
_____	_____
_____	_____

Patient Name: _____ Date of Birth _____

Past Medical History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Autoimmune Disorders
- ☐ Back Problems
- ☐ Bleeding
- ☐ Blood Disorders
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Clotting Disorder
- ☐ Colon Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorders
- ☐ Ear Problems
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Defects
- ☐ Hepatitis A,B,C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Liver Disorder
- ☐ Kidney Disorder
- ☐ Joint Disorder
- ☐ Lung Disorder
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Illness
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Skin Disorder
- ☐ Tuberculosis
- ☐ Seually Transmitted Disease

Other Details _____

Family Medical History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Autoimmune Disorders
- ☐ Back Problems
- ☐ Bleeding
- ☐ Blood Disorders
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Clotting Disorder
- ☐ Colon Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorders
- ☐ Ear Problems
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- ☐ Substance Abuse
- ☐ Skin Disorder
- ☐ Tuberculosis
- ☐ Seually Transmitted Disease

Other Details _____

Patient Name: _____ Date of Birth _____

Past Surgical History

Surgery: _____ Date: _____ Where: _____

Surgery: _____ Date: _____ Where: _____

Surgery: _____ Date: _____ Where: _____

IF more surgeries please list on back of page.

Lifestyle

Are you sexually active? ☐ Yes ☐ No

How many partners? _____ Past Year _____ Total Lifetime _____

If not currently active, have you ever been sexually active? ☐ Yes ☐ No

Sexual Partner (s) is/are ☐ Male ☐ Female ☐ Both

Would you like to be checked for sexually transmitted diseases? ☐ Yes ☐ No

Has anyone in your home physically or verbally hurt you? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How many packs per day? _____

Have you ever smoked? ☐ Yes ☐ No Quite Date _____

Do you use recreational drugs? ☐ Yes ☐ No

If drug use what type/frequency? _____

How much alcohol do you drink per week? _____

How much caffeine do you drink per day? _____

How many times per week do you exercise? _____

How tall are you? _____

Patient Name: _____ Date of Birth _____

Pregnancy History

Are you currently Pregnant? ☐ Yes ☐ No

Number of Pregnancies _____ Term Pregnancies _____

Preterm Pregnancies _____ Miscarriages _____ Abortions _____

Date:	#weeks	Type of Delivery	M/F	WT	Living	Complications

Are you trying to become pregnant? ☐ Yes ☐ No

What is your current method of birth control? ☐ N/A ☐ Abstinence ☐ Condoms

☐ Intrauterine Device ☐ Implanon/Nexplanon ☐ Vaginal Ring (Nuva Ring)

☐ Contraceptive Patch ☐ Spermicide ☐ Withdrawal

☐ Natural Family Planning/Rhythm Method ☐ Diaphragm/cervical cap

☐ Oral Contraceptive pills: (name) _____ ☐ Other: _____

Patient Name: _____ Date of Birth _____

Menstrual/Health History

Age at first period? _____

Date of last period? _____

Frequency of periods? _____

Length of period? _____

Are your periods regular? ☐ Yes ☐ No

Age at menopause? _____

Last pap smear? _____

Last mammogram? _____

Last bone density? _____

Last colonoscopy? _____

Last general health check up? _____

Immunizations up to date? ☐ Yes ☐ No

OB/GYN History

☐ Abnormal Vaginal Bleeding
☐ Abnormal pap smear
☐ Bleeding between periods
☐ Breast Lump/mass
☐ Breast Cancer
☐ Breast Surgery
☐ Cervical Cancer
☐ Cervical Dysplasia
☐ Herpes
☐ HIV (Human Immunodeficiency Virus)
☐ Chlamydia
☐ Colposcopy
☐ Cryosurgery
☐ DES exposure
☐ Fecal/Flatus Incontinence
☐ Fibroids
☐ Genital Warts
☐ Gonorrhea
☐ Painful intercourse
☐ Hot Flashes
☐ HPV (Human Papilloma virus)
☐ Infertility
☐ Irregular Periods
☐ Nipple Discharge
☐ Ovarian Cysts
☐ Ovarian Cancer
☐ Yeast
☐ Pelvic/Inflammatory Disease
☐ Menstrual Pain
☐ Uterine Cancer
☐ Uterine Hyperplasia
☐ Urinary Incontinence
☐ UTI - frequent
☐ Vaginitis (BV)
☐ RPR (syphilis)