UNIVERSITY OF WYOMING

Albany Community Health Clinic
920 E. Sheridan St., Suite A
Laramie, WY 82070
(307) 460 – 9039
Email: achc@uwyo.edu

Annual and New Patient Medical Information Intake

Full Name: _____ Date of Birth: _____

Reason for today's visit: _____

Current Medications Preferred Pharmacy:_____

Medication	Dose	How Often	Medication	Dose	How Often
Example: Lisinopril	10 mg	1 a day			

Allergies to Medications □Yes □ No Please describe drug(s) and reaction:

_____

_____

Do you use tobacco?
□ No, Never smoker
□ Passive smoke exposure
□ Yes, Current smoker
What do you smoke? _____
Year started:_____ Amount pack/day:_____
□ Former smoker
What did you smoke? _____
Year quit:_____ How many years did you smoke?_____ How many packs/day?_____

In general, how would you rate your health?
□ Excellent □ Very good □ Good □ Fair □ Poor

Pain Screen:
Are you currently having any pain you would like your provider to address? □ Yes □ No
Are you currently having any pain that affects your activity level? □ Yes □ No

Depression Screen:
Over the last **two weeks**, have you…
1) Had little interest or pleasure in doing things?
□ Not at all
□ Several days
□ More than half the days
□ Nearly every day

2) Been feeling down, depressed, or hopeless?
□ Not at all
□ Several days
□ More than half the days
□ Nearly every day

Past Medical History (Please **√**)

□ Abnormal Pap test
□ ADHD
□ Alcohol Use Disorder
□ Anemia
□ Anesthesia Problem
□ Anxiety
□ Asthma
□ Atrial Fibrillation
□ Autoimmune Disorder
□ Bipolar Disorder
□ Blood Transfusion
□ Breast Cancer or abnormal mammogram
□ Cancer, type_____
□ Chronic Renal Failure
□ Cirrhosis of liver
□ Congestive Heart Failure
□ COPD
□ Crohns Disease
□ Depression
□ Diabetes, Type: _____
□ Diverticulitis/Diverticulosis
□ DVT/Blood Clots in Legs
□ GERD (Reflux)
□ GI Bleed
□ Gynecologic problems
□ Heart Attack (MI)
□ Heart Disease
□ Hemochromatosis
□ High Blood Pressure
□ High Cholesterol
□ Hepatitis, Type _____
□ Infertility
□ Irritable Bowel Syndrome
□ Kidney Disease
□ Kidney Stone(s)
□ Liver Disease
□ Metabolic Syndrome
□ Migraine Headaches
□ Neurologic Disorder
□ Osteoarthritis
□ Osteoporosis (“thin bones”)
□ Pancreatitis
□ Peripheral Vascular Disease
□ Rheumatoid Arthritis
□ Seizure Disorder
□ Stroke
□ Thyroid problem
□ Tuberculosis History
□ Ulcerative Colitis
□ Urinary incontinence (“leaking urine”)
□ Urinary Tract Infections
□ Valvular Heart Disease

Other Issues Not Listed:

_____

_____

_____

Past Surgical History (Please **√**)

□ AAA Repair
□Abdominal Surgery:_____
□ Amputation
□ Angioplasty
□ AV Fistula Creation
□ AV Graft
□ Appendix Removal
□ Brain Surgery
□ Breast Surgery
□ Bronchoscopy
□ CABG (Heart Bypass)
□ Carotid Endarterectomy
□ Carpal Tunnel
□ Cataract Surgery
□ C-Section
□ Colon Surgery
□ Colostomy
□ Gallbladder Removal

□ Gastric Bypass
□ Heart valve surgery
□ Hemorrhoid Removal
□ Hernia Repair
□ Hysterectomy
□ Joint replacement:_____
□ Kidney Removal or Transplant
□ Knee Arthroscopy
□ Lap Band-Gastric
□ Lung Surgery
□ Ovary Removal
□ Pacemaker
□ Pain Injections:_____

□ Prostate Surgery
□ Rotator Cuff Repair
□ Spine Surgery
□ Stent placement
□ Thyroid surgery
□ Tonsillectomy
□ Tubal Ligation (female tubes tied)
□Urinary Incontinence Surgery
□ Vasectomy (male tubes tied)
□ Wisdom tooth removal

Surgical complications: _____

_____

Other Surgeries Not Listed:

_____

_____

_____

Do you have a <u>Family History</u> of any of the following? (Please **√** and write which relative in the blank- only check if it pertains to mother, father, sister, brother, or grandparent):

□ Adopted □ Unknown
□ Alcoholism _____
□ Anemia _____
□ Anesthetic Complication _____
□ Anxiety _____
□ Arthritis _____
□ Asthma _____
□ Birth Defects _____
□ Bleeding Disorder _____
□ Breast Cancer _____
□ Colon Cancer _____
□ Depression_____
□ Diabetes _____
□ Heart Disease _____

□ Heart Attack before age 55_____
□ Heart Attack before age 65_____
□ High Blood Pressure _____
□ High Cholesterol _____
□ Kidney Disease _____
□ Lung Cancer _____
□ Lung Disease _____
□ Melanoma _____
□ Mental Illness_____
□ Migraines _____
□ Osteoporosis_____
□ Ovarian Cancer _____
□ Seizures _____

□ Severe Allergies _____
□ Stroke _____
□ Sudden death _____
□ Thyroid Disease _____
□ Uterine Cancer _____

Other Issues Not Listed:

_____

_____

_____

_____

<u>Social History</u> (Please **√**)

<u>Relationship status:</u>
□ Recent change in relationship status
□ Single
□ Dating
□ Divorced
□ Engaged
□ Partnered
□ Married
□ Separated
□ Widowed/Widower

<u>Residence status:</u>
Homeless □ Yes □ No

<u>Work and Education:</u>
□ Employed
□ Unemployed
□Student
□ Retired
□ Disabled
Occupation:_____
Highest level of education:_____

Sexual History and Information:

Sex at birth:
□ Male
□ Female
□ Intersex

Sexual orientation:
□ Heterosexual
□ Homosexual (Gay)
□ Homosexual (Lesbian)
□ Bisexual
□ Something else
□ Don't know
□ Choose not to disclose

Gender identity:
□ Male
□ Female
□ Transgender (male to female)
□ Transgender (female to male)
□ Other
□ Choose not to disclose

Alcohol use:
□Current:
Type:_____ Amount/day:_____
□Past or current alcohol problem
□Previous
□ Never

Drug use:
□Current:
Type:_____ Amount/day:_____
□Past or current substance problem
□Previous
□ Never

Abuse History:
□ History of physical abuse
□ History of sexual abuse
□ History of emotional abuse

Do you feel safe at home? □ Yes □ No

Preventative Care:

Exercise:
Type and times/week _____

Healthy Diet, including fruits and vegetables:
□ Always□ Sometimes □Never

Seatbelt Use:
□ Always□ Sometimes □Never

Cancer Screening:
Have you ever had a Colonoscopy?
□ Yes, Date:_____ Results □ normal □ abnormal
□ No

Female sex only:
Have you ever had a Pap test?
□ Yes, Date:_____ Results □ normal □ abnormal
□ No

Have you ever had a mammogram?
□ Yes, Date:_____ Results □ normal □ abnormal
□ No