UNIVERSITY OF WYOMING

Family Medicine Residency Program
820 East 17th Street
Cheyenne, WY 82001
(307) 632-2434

Patient Medical Information Initial Intake

Patient Name: _____ Date of Birth: _____

Reason for Today's Visit: _____

Current Medications

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

Allergies to medications? YES / NO If yes, what medication(s) and what reaction(s)?

_____

_____

Please list any past medical history concerns:

_____

_____

Please List any Surgeries:

_____

_____

Please list Family History (for example: mother with migraine headaches); (Please list only medical problems for Brothers, sisters, mother, father, and grandparents)

_____

_____

Please check the boxes that apply to your Social Situation: Please check all that applies:

Are you homeless? ☐ Yes ☐ No

☐ Single
☐ Married
☐ Divorced
☐ Widowed /Widower

☐ Employed
☐ Retired
☐ Unemployed
☐ Disabled

Occupation: _____

Medical Risk Factors: Please check all that apply

Tobacco Use:

☐ Currently Using/Year Started: _____
☐ Type(s) of Tobacco Using/Used: _____
☐ Amount per Day: _____
☐ Quit/Year Quit: _____
☐ Passive/second hand smoke exposure: How Many Years? _____

Alcohol Use:

☐ No ☐Yes – How Often _____

Illegal Drug Use

☐ No ☐Yes – How Often _____

Have You Ever Had:

Colonoscopy: ☐ No ☐ Yes When/Where? _____

(For Women Only)

Mammogram: ☐ No ☐ Yes When/Where? _____

Pap Smear: ☐ No ☐ Yes When/Where? _____