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| **Wyo Central Health Services, LLC**  **Patient History Intake** | | | |
| Name: | | Birthdate: | |
| Marital Status: | | Occupation: | |
| Biological Sex: Male/Female | | Gender Identity: Male/Female/Transgender/Transsexual | |
| **Allergies (Medications, Food, Latex, Dyes)** | | | |
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| **Medications (Prescription, Non-Prescriptions, Herbs, Vitamins, Supplements)** | | |
| Name | Dose | Frequency |
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| **Surgeries/Hospitalizations/Serious Injuries** | **Mo/Year** |
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| **Immunizations Yes No Yes No** | | | | | |
| Hepatitis B Series |  |  | Pneumonia Vaccine |  |  |
| Gardasil Series |  |  | Influenza Vaccine |  |  |
| Chicken Pox (vaccine or disease) |  |  | Positive TB Testing/Chest XRay |  |  |

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| **Health Maintenance Yes No Mo/Year Yes No Mo/Year** | | | | | | | |
| Colonoscopy |  |  |  | Bone Density |  |  |  |
| Mammogram |  |  |  | Eye Exam |  |  |  |
| Pap Smear |  |  |  | Physical Exam |  |  |  |
| Dental Exam |  |  |  |  |  |  |  |

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| **Social History Yes No** | | | |
| Tobacco Use |  |  | Smoke/Chew/Vape Packs/Cans/Day: Years of Use: Year Quit: |
| Alcohol Use |  |  | Type: Drinks/Day: Drinks/Week: Age of First Drink: |
| Caffeine Use |  |  | Type: Drinks/Day: |
| Recreational Drug Use |  |  | Type: Route: Frequency: Last Use: Years Sober: |
| Special Diet |  |  | Type: |
| Regular Exercise |  |  | Intensity: Time: Frequency: |
| Sexually Active |  |  | Men: Women: Both: |

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| **GYN History OB History** | |
| Age of first menses: Menopausal: Age: | Total # of Pregnancies: |
| Regular Cycles: Painful Cycles: | Full Term: Pre-Term: |
| PMS: Describe (if yes): | Miscarriages: Abortions: |
| Abnormal PAP: When(if yes): | Eptopics: |
| Painful Intercourse: Describe (if yes): | |

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| **Medical History (Mark if you have a personal history of any of the following)** | | | | | |
| **ENT** | | **Genitourinary** | | **Skin** | |
|  | Eye Problems |  | Urinary Infections |  | Psoriasis |
|  | Sinus Problems |  | Kidney Disease/Stones |  | Rashes |
|  | Hearing Loss |  | Erectile Dysfunction |  | Melanoma |
|  |  |  | STD |  |  |
| **Cardiovascular** | |  | Urinary Incontinence |  |  |
|  | Abnormal EKG | **Musculoskeletal** | | **Mental Health** | |
|  | Chest Pain |  | Arthritis |  | ADD/ADHD |
|  | Heart Attack |  | Gout |  | Anxiety |
|  | Heart Disease |  | Neck/Spine Problems |  | Depression |
|  | High Blood Pressure |  |  |  | Memory Loss |
|  | High Cholesterol | **Endocrine** | |  | OCD |
|  | Stroke |  | Diabetes |  | Suicidal Thoughts/Attempts |
|  | Peripheral Vascular Disease |  | Thyroid Disease |  |  |
|  |  |  | Pancreatitis |  |  |
| **Pulmonary** | |  |  |  |  |
|  | Asthma | **Neurological** | |  |  |
|  | Emphysema/COPD |  | Concussion |  |  |
|  | Shortness of Breath |  | Headaches |  |  |
|  | Sleep Apnea |  | Seizures |  |  |
| **Gastrointestinal** | |  |  |  |  |
|  | Acid Reflux |  |  |  |  |
|  | Constipation | **Hemotological** | |  |  |
|  | Diarrhea |  | Anemia |  |  |
|  | Irritable Bowel |  | Bleeding Disorders |  |  |
|  | Gallbladder Disease |  | Blood Clots |  |  |
|  | Hernia |  | Cancer |  |  |
|  | Liver Disease |  | Sickle Cell Disease |  |  |
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| **Family History (Mark if you have family members with a history of any of the following)** | | | | | | | | | |
| Illness | Father | Mother | Sibling | Child | Maternal  G-Ma | Maternal  G-Pa | Paternal  G-Ma | Paternal  G-Pa | Other |
| Asthma |  |  |  |  |  |  |  |  |  |
| Bleeding Disorder |  |  |  |  |  |  |  |  |  |
| Breast Cancer |  |  |  |  |  |  |  |  |  |
| Colon Cancer |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |
| Drug Addiction |  |  |  |  |  |  |  |  |  |
| Alcoholism |  |  |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |  |  |
| Leukemia |  |  |  |  |  |  |  |  |  |
| Liver Disease |  |  |  |  |  |  |  |  |  |
| Lung Cancer |  |  |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |  |  |
| Ovarian Cancer |  |  |  |  |  |  |  |  |  |
| Pancreatic Cancer |  |  |  |  |  |  |  |  |  |
| Rheumatoid Arthritis |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |
| Thyroid Disease |  |  |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |  |  |