Cheyenne Medical Specialist, P.C
5050 Powderhouse Road
Cheyenne, Wyoming 82009
(307) 634-1311

Today's date: _____ Previous Physician: _____

PLEASE PRINT- This information will become a part of your confidential medical records.

Name: _____ Date of Birth: _____
Martial Status: S M D W Are you right or left handed: _____
Please state your **CHIEF COMPLAINT** (main problem for seeking medical treatment at this time)

_____
_____
_____

Past Medical History (give names and dates):

Hospitalizations: _____
Major Illnesses: _____
Surgeries: _____
Fractures: _____

Mark any of the following health conditions that apply to you:

Diabetes	Serious Accident	Heart Attack
Significant weight change	Stroke	Ulcers
High Blood Pressure	Lung Disease	Cancer
Serious Infection	Headache	Seizure

Current Medications: _____

Sleeping Pills	"Hard Drugs"	Water Pills (diuretic)
Antacids	Cortisone Steroids	Asthma pills
Digitalis	Antidepressant	Laxative
Diabetic pills	Vitamins	Heart Pills
Diet Pills	Tranquilizer	Estrogen Hormone
Antibiotic	Decongestant	Blood Thinner
Birth control pills	Nitroglycerin	Thyroid
Pain pills	Iron	Insulin

Drug Allergies: Specify any drug reaction or allergy: _____

Do you have any religious objections to a blood transfusion? Yes_____ No _____

Family Member	Age if living	Age at death	Present condition or cause of death
Father			
Mother			
Brothers: How many?			
Sisters: How many?			
Children How Many?			

Check if any relatives have had:

Diabetes
Paralysis
Thyroid trouble
Migraines/headaches
MS
Parkinson's

Alzheimer's
Neuropathy (tingling/numb feet)
Arthritis
Heart trouble
Mental Illness

Stroke
Muscle disease
Suicide
Obesity
High blood pressure

Social History:

Type of work: Self: _____ Employed now? Yes ____ No ____
Spouse: _____ Employed now?Yes ____ No ____

Education:

Year completed _____ Grade _____ High _____ Vocational ____ College ____

Smoking:

Pipe
Packs per day ____

Cigar
No. of years ____

Chew
Year stopped ____

Alcohol:

Never ____ Occasional ____ Moderate ____ Heavy ____

Caffeine:

Coffee ____ Tea ____ Soft Drinks ____ Cups per day ____

Aspirin:

Tablets per day? ____

Systems Review: Check any of these symptoms or problems that bother you lately:

Tired all the time
Don't feel well
Weakness
Weight Problem
Fluid Retention
Lack of exercise
Last physical exam _____
Headache
Migraine
Fainting
Epilepsy/seizure
Ear/hearing problem
Ringing in the ears
Stuffy nose
Nose bleeds
Sinus trouble
Dental problems
Last dental exam _____
Persistent hoarseness
Vision/eye trouble
Glaucoma
Cataract
Last eye exam _____
Frequent cough
Cough phlegm
Cough blood
Frequent chest colds
Bronchitis
Pneumonia
Shortness of breath
Asthma/wheezing
Pleurisy
Chest pain
Heart trouble

Heart Murmur
Heart palpitations/racing
Chest tightness/pressure
Angina
Tire easily
Enlarged heart
Rheumatic fever
Leg pain on walking
Phlebitis
Varicose Veins
Arthritis/joint pain
Gout
Neck pain
Back pain or trouble
Bursitis/tendonitis
Swallowing trouble
Indigestion
Heartburn
Nervous stomach
Ulcers
Vomiting blood
Black or bloody stools
Rectal bleeding
Abdominal pain
Nervous or spastic colon
Colitis
Diarrhea
Constipation
Change in bowel habits
Hemorrhoids
Gallbladder trouble
Yellow jaundice
Liver disease
Hernia

Nervous irritable
Bored
Depressed
Trouble sleeping
Marital Problems
Job problems
Nervous breakdown
Psychiatrist seen
Sugar in urine
Hypoglycemia
Low blood sugar
Thyroid trouble
Urine/bladder infection
Bladder problem
Kidney infection
Kidney Stone
Difficulty w/ urination
Protein or blood in urine
VD
Skin trouble
Allergy
Bleed or bruise easily
Anemia
Bloody discharge
Discharge from penis
Prostrate trouble
Stream weak or slow
Swelling/pain in testes
nfertility proble,
Sexual Difficulty
Birth control used _____

For Women Only

Age menstruation began ____
Period every ____
Flow last (how many days) ____
Date of last period ____
Spotting ____
Date of last pap smear ____

Menstrual problems ____
Period heavy ____
Irregular ____
Painful ____
Infrequent ____
Other ____

Any of these problems?

Hot flashes? ____
Vaginal Discharge ____
Infertility ____

Sexual difficulty ____
Breast lump ____
Breast discharge ____

Number of pregnancies ____

Number of miscarriages ____