



5050 Powderhouse Rd  
Cheyenne, WY 82009

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex: M F

Place of Birth: \_\_\_\_\_

Religion: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Other number where you can be reached?  
\_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Past Occupations: \_\_\_\_\_

Person to notify in case of Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

History: Present problems briefly in your own words. If several problems, list separately:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Family History	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brother/Sister				
Husband/Wife				
Children				

**Is there any of the following in your blood relatives? (circle and give relationship)**

Stroke: _____	Cancer: _____	Bleeding Tendency: _____	<i>Psychiatric or Nervous Disorder:</i>
Heart Disease: _____	Leukemia: _____	Ulcers: _____	Suicide: _____
High Blood Pressure: _____	Tuberculosis: _____	Bowel Disease: _____	Mental Illness: _____
Kidney Disease: _____	Diabetes: _____	Thyroid Disease: _____	Nervous Breakdown: _____
Rheumatic Heart: _____	Epilepsy: _____	Arthritis: _____	
Migraine: _____	Asthma: _____		

**Personal Habits (circle)**

Tobacco:Cigarettes, pipe, cigars, chew: Ever? \_\_\_\_\_ How much? \_\_\_\_\_ How Long? \_\_\_\_\_

Drink: Hard liquor, beer, wine. How much? \_\_\_\_\_ How long? \_\_\_\_\_

Caffeine: How many cups per day? \_\_\_\_\_ Tetanus series? \_\_\_\_\_ Booster? \_\_\_\_\_

Flu shot yearly? YES NO Pneumonia vaccine ever? YES NO

Recreational drugs? What kind? \_\_\_\_\_ How much? \_\_\_\_\_

Exercise: What kind? \_\_\_\_\_ How much? \_\_\_\_\_

Sexual habits: \_\_\_\_\_

List your current medications including prescription, over-the-counter, vitamins, herbal supplements, etc.: \_\_\_\_\_

List operations and year performed: \_\_\_\_\_

Have you had a blood transfusion? YES NO When? \_\_\_\_\_

List drugs to which you are allergic: \_\_\_\_\_

How were you allergic? Circle if appropriate: rash, difficulty breathing, nausea, vomiting, diarrhea, palpitation, bloody urine

List other allergies: \_\_\_\_\_

List serious diseases or illnesses, date and whether or not hospitalized: \_\_\_\_\_

List serious injuries or accidents: \_\_\_\_\_

Circle if you have had: Measles, Mumps, Chicken Pox, Whooping Cough, Scarlet Fever, Diphtheria, Polio, Smallpox, Typhoid, Malaria, Gonorrhoea, Syphilis, Hepatitis, Meningitis

Have you ever had or been treated for (circle appropriate term)

- (a) Convulsions, dizziness, fainting spells, epilepsy, loss of consciousness, severe or frequent headaches, nervousness, mental illness, stroke or any other disorder of the brain or nervous system.
- (b) Rheumatic fever, heart murmur, heart attack, angina pectoris, stroke, chest pain, shortness of breath, palpitations, irregular pulse, elevated blood pressure, varicose veins or any other disorder of the heart or blood vessels?  
Awaken at night short of breath? Get up to pass urine at night?
- (c) Tuberculosis, persistent cough or hoarseness, pneumonia, emphysema, pleurisy, blood spitting, asthma, hay fever or any other disease of the lungs or respiratory system?
- (d) Hepatitis, yellow jaundice, liver problems, pancreatitis, diabetes, gall bladder stones or gall bladder disease, duodenal or gastric ulcer, nervous stomach, indigestion, appendicitis, colitis, diverticulitis, hemorrhoids, bleeding from the intestinal tract or any other disease of the stomach, intestines or rectum, or had recent gain or loss of more than 15 pounds? Vomiting blood, rectal bleeding? Date of last sigmoidoscopic exam: \_\_\_\_\_
- (e) Nephritis, kidney stone or colic; sugar, albumin, blood or pus in urine; sexually transmitted disease, urinary incontinence, painful intercourse, sexual dysfunction, impotence or any other disorder of the prostate, bladder, kidney or genitourinary system?

- (f) Any disorder of the breast or pelvic organs or any other female disorder, including abnormal pregnancy or are you now pregnant? Date of last Pap: \_\_\_\_\_ Date of last Mammogram: \_\_\_\_\_
- (g) Any impairment or loss of sight, hearing or speech or any disorder of eyes, ears, nose or throat, wear glasses (exclude common colds and sore throats):
- (h) Arthritis, rheumatism, gout, osteoporosis, neuritis, sciatica or other disorder of, or injury to, bones or joints including back of spine
- (i) Paralysis, deformity, lameness or any other impairment of function or loss of hand, arm, shoulder, foot, leg or hip?
- (j) Cancer, cyst, tumor, hernia of any kind; anemia or other blood disorder; syphilis, diabetes, disease of the thyroid or any other gland; dermatitis, eczema or other skin disease? If you did have cancer, cyst or tumor, state what organ:
- (k) Alcoholism or the excessive use of alcohol, or any drug habit? Treatment: \_\_\_\_\_
- (l) Do you have any reason to believe you are not in good health at the present time? If so, why? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- (m) Hazardous material exposure at work? \_\_\_\_\_
- (n) Foreign travel or military service? \_\_\_\_\_

Reviewed by: \_\_\_\_\_

**TO BE COMPLETED BY DOCTOR:**

T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ V: \_\_\_\_\_ WITH/WITHOUT

**Abnormal (circle)**

- YES NO Skin:** Nevi, actinic changes, psoriasis, texture \_\_\_\_\_, cyanotic
- YES NO Nodes:** Enlarged, tender, location: \_\_\_\_\_
- YES NO Ears:** (a) Ext. auditory canal: R L Acuity: L /  
 (b) Tympanic membrane: R L R /
- YES NO Eyes:** Icterus, hemorrhage, pupils, unequal, unreactive irregular fundi-hemorrhage, exudates, nicking, Increased light reflex, papilledema, pigment OD OS EOM Acuity: L /  
 R /
- YES NO Nose:** Septal deviation, polyps, congestion: R L
- YES NO Mouth:** Dentures, upper, lower. Caries, location: \_\_\_\_\_
- YES NO Pharynx:** Red, dry, injected, uvular deviation. Palate: \_\_\_\_\_
- YES NO Tonsils:** Enlarged, red, pus, absent.
- YES NO Neck:** Nodes, NVD, enlarged thyroid, bruits; NVD: \_\_\_\_\_ °
- YES NO Chest:** Lesions, deformity, retractions, barrel
- YES NO Back:** \_\_\_\_\_
- YES NO Breasts:** Masses - R, L. If mass: hard, soft, movable Y N size, tender
- YES NO Lungs:** Rales, dullness, fremitus, rhonchi, wheezes. Location: \_\_\_\_\_

**YES NO** Heart: Pulses: regular, irregular, decreases in any area. Location: \_\_\_\_\_  
 Enlarged \_\_\_\_\_  
 Murmurs: Systolic – holo, ejection, early, mid, late      Pulses – Grade 4/4  
 Diastolic      Carotid  
 Location      Brach  
 Radiation      Rad  
 Character      Ulnar  
 Grade -/6      Fem  
 Gallop: S4, S3      Pop  
 Click: timing      DP  
 Thrills: Timing, location: \_\_\_\_\_      PT

**YES NO** Abdomen: Inspection: distention, obese, scaphoid, muscular  
 Palpation: Liver, spleen masses: \_\_\_\_\_  
 Tenderness, location: \_\_\_\_\_  
 Percussion: Liver, spleen masses: \_\_\_\_\_  
 Tenderness, location: \_\_\_\_\_  
 Auscultation: bruits, BS active, hypoactive, absent, hyperactive.

**YES NO** Genitalia: Male: Discharge, lesion, mass Location: \_\_\_\_\_  
 Hernias: \_\_\_\_\_  
 Pap: Female: Discharge, Cx lesion, uterus mass, ovary mass, other: \_\_\_\_\_  
 Hernias: \_\_\_\_\_  
 Pap: Vag. \_\_\_\_\_ Cx \_\_\_\_\_

**YES NO** Rectum: Hemorrhoid, fissure, prostate enlargement, mass \_\_\_\_\_

**YES NO** Extremities: Edema, cyanosis, clubbing, varicose veins: \_\_\_\_\_

**YES NO** Neurological: Cerebral: oriented to person, place time  
 Cerebellum: ataxia, nystagmus, past pointing  
 Cranial nerves, I, II, III, IV, V, VI, VII, VIII, IX, X, XI, XII  
 Motor  
 Sensory  
 Vibratory (position)  
 Reflexes  
 Babinsky or Hoffman  
 Clonus – Location: \_\_\_\_\_

Impression:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Lab Ordered:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Plan:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_