CAMPBELL COUNTY MEMORIAL HOSPITAL
501 SOUTH BURMA AVENUE
GILLETTE, WYOMING 82716

NEW PATIENT INTAKE
Patient Medical History

Date: ________________________ Age: _____________ Married / Divorced / Widowed / Single

Social History: Primary language ____________________________ Do you need a translator? ☐ Yes ☐ No

Schooling completed: ____

Employer / Occupation: ____

If retired or unemployed, what did you do prior? ____

Do you have children? ☐ No ☐ Yes, how many? ____

Do you live alone? ☐ Yes ☐ No Who lives with you?______________________________________

Do you have pets? ☐ Yes ☐ No What kinds? ____

Do you smoke?

- ☐ Yes, I've smoked _______ packs of cigarettes/cigar/pipe per day for _______ years.
- ☐ Smokeless tobacco (chew) _______ cans/day ☐ E-Cigarettes.
- ☐ No, I quit _______ years ago. I was smoking _______ packs per day for _______ years.
- ☐ No, I have never smoked.
- ☐ Interested in smoking cessation?

Do you drink alcohol?

- ☐ No, never (rarely) ☐ But I used to.
- ☐ Yes, ________times/week or ________times/month.

Have you been exposed to chemicals or toxins? Yes No

If yes, please explain____

____

MEDICATIONS: **<u>Include over-the-counter medications</u> (i.e., Tylenol, Ibuprofen, vitamins and supplements).**

DRUG NAME	DOSE: MG/UNITS/TABLETS	REASON

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ALLERGIES

Please list **all Allergies and Reaction** to medication, food, plants, pollen, I.V. contrast (dye used in x-ray procedures), sensitivity and/or itching to any latex products (**such as gloves, balloons, condoms etc.**), or any other known allergies.

NAME OF SUBSTANCE	REACTION	NAME OF SUBSTANCE	REACTION

Family Member	Name of Chronic Illness of Family Member
Biological Mother	
Biological Father	
Siblings	
Maternal Grandmother	
Paternal Grandmother	
Maternal Grandfather	
Paternal Grandfather	
Aunt(s)	
Uncle(s)	

***For Women:**

How old were you when you had your first menstrual period? ______________________Last period?_______________

If you stopped having periods, was it due to a hysterectomy or natural? ______________________Age_____________

How many times were you pregnant? _______________Miscarriages?__________ Live Births?___________________

How old were you when you gave birth to your first born? __________________________ Last born? _____________

Have you taken any fertility treatments in the past? ____

How many cycles and what kind? ____

Have you taken any birth control pills in the past? ___________________________# of years? __________________

Have you taken hormonal replacement therapy (HRT)? ____

If you have taken or are taking HRT, how long have you taken them or since when? __________________________

Are any of your predecessors (parents, grandparents) of Ashkenazi Jewish, Icelandic or French Canadian ethnicity?
____

Please list dates of last:

Eye Exam________________ Dental Exam________________ Colonoscopy__________________

(Women Only) Mammogram___________________ Pap/Pelvic Exam_________________

Have you ever had Chemotherapy? Yes No Date: __________________________

If yes, at what facility was it done? ________________________________

If you can please list the chemotherapy drugs that you previously received: ___________________________________
____

Have you ever had Radiation therapy? Yes No Date: __________________________

If yes, at what facility was it done? ____

What part of your body was treated? ____

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Have you ever had any of the following? *(✔ If you have ever had any of the following)*

Heart Disease	Tuberculosis (TB)
High Blood Pressure	Hepatitis
Stroke	HIV/AIDS
Kidney Problems	Lung Disease
Asthma	Gastrointestinal
Seizures	Cancer
Thyroid	Auto-immune disease (Lupus, Rheumatoid Arthritis, Scleroderma)
Mental Illness ***(depression/anxiety)***	Chronic Disease (Ulcers, ulcerative colitis, Crohn's Disease)
Substance Abuse	Osteoporosis

Do you have any other active or inactive health problems?

____
____
____
____

Please indicate whether you have experienced any of the following problems or conditions:

GENERAL			CARDIOVASCULAR		
Fever, Chills, Sweats	YES	NO	Bleeding Problems	YES	NO
Body Piercing / Tattoos	YES	NO	Blood Clots	YES	NO
General Weakness	YES	NO	Irregular Heartbeat	YES	NO
Cold most of the time	YES	NO	Palpitations	YES	NO
Thirsty all of the time	YES	NO	High Blood Pressure	YES	NO
Unusually Tired / Sluggish	YES	NO	Rheumatic Fever	YES	NO
Weight Loss, If yes how much?	YES	NO	Heart Valve Problem or Murmur	YES	NO
Unexplained Fatigue	YES	NO	Arm or Leg Pain / Cramps	YES	NO
Palpable Lumps or Bumps	YES	NO	Arm or Leg Swelling	YES	NO
Sores that won't heal	YES	NO	Heart Attack	YES	NO
			Congestive Heart Failure	YES	NO
HEENT			**GASTROINTESTINAL**		
Blurred or double vision	YES	NO	Poor Appetite	YES	NO
Light Flashes	YES	NO	GF Reflux Disease	YES	NO
Pain in Eyes	YES	NO	Indigestion or Heartburn	YES	NO
Glaucoma	YES	NO	Stomach Ulcer	YES	NO
Ear Pain	YES	NO	Nausea or Vomiting	YES	NO
Drainage from Ears	YES	NO	Diarrhea or Constipation	YES	NO
Buzzing or Ringing in Ears	YES	NO	Blood in Stool or Black Stool	YES	NO
Hearing Loss	YES	NO	Change in Bowel Habits	YES	NO
Nosebleeds	YES	NO	Pain with Bowel Movements	YES	NO
Sinus Problems	YES	NO	Abdominal Swelling	YES	NO
Problem Swallowing	YES	NO	Uncontrolled Loss of Stool	YES	NO
Sore Throat or Mouth	YES	NO	High Cholesterol	YES	NO
Persistent Hoarseness	YES	NO	Hepatitis or Liver Disease	YES	NO
Difficulty Opening Mouth	YES	NO	Yellow Skin or Eyes	YES	NO
Neck Pain or Swelling	YES	NO	Abdominal Pain/Cramps	YES	NO
Headaches	YES	NO			

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RESPIRATORY

Coughing up Blood	**YES NO**
Frequent Cough	**YES NO**
Night Sweats	**YES NO**
Shortness of Breath	**YES NO**
Wheezing	**YES NO**
Asthma	**YES NO**
COPD or Emphysema	**YES NO**
Tuberculosis	**YES NO**
Sleep Apnea	**YES NO**
Oxygen Use	**YES NO**
Chest Pain	**YES NO**
Bronchitis or Pneumonia	**YES NO**

MUSCULOSKELETAL

Painful / Swollen Joints	**YES NO**
Lumps / Swelling Muscles	**YES NO**
Pain in Bones	**YES NO**
Back Problems	**YES NO**
Osteoporosis	**YES NO**
Muscle Disorder (Myasthenia Gravis, etc.)	**YES NO**
Rheumatoid Arthritis	**YES NO**

GU

Painful / Burning Urination	**YES NO**
Frequent Urination	**YES NO**
Uncontrolled Loss of Urine	**YES NO**
Little warning prior to urination	**YES NO**
Trouble Starting Stream	**YES NO**
Blood in Urine	**YES NO**
Kidney Stones	**YES NO**

MALE GU

Sore or Discharge from Penis	**YES NO**
Pain or Blood with Ejaculation	**YES NO**
Lump in Testicle	**YES NO**
Difficulty achieving an erection	**YES NO**

PSYCH / NEURO

Weakness	**YES NO**
Headaches	**YES NO**
Tingling or Numbness	**YES NO**
Dizziness or Vertigo	**YES NO**
Fainting Spells	**YES NO**
Trouble with Balance	**YES NO**
Shooting Pains	**YES NO**
Unusual Behavior Changes	**YES NO**
Memory or Intellectual Changes	**YES NO**
Unusual Emotional Changes	**YES NO**
Seizures	**YES NO**
Depression	**YES NO**
Anxiety	**YES NO**
Suicide Attempt	**YES NO**

ENDOCRINE

Diabetes	**YES NO**
Low Blood Sugar	**YES NO**
Thyroid Problems	**YES NO**

HEMATOLOGICAL

Cancer or Leukemia	**YES NO**
Ever Received Blood	**YES NO**

GYN

Breast Lump	**YES NO**
Pain in Breast	**YES NO**
Nipple changes or discharge	**YES NO**
Vaginal Discharge	**YES NO**
Pain with sexual intercourse	**YES NO**
Vaginal Bleeding or Spotting	**YES NO**
between Menses	**YES NO**

CURRENT DOCTORS INCLUDING PRIMARY CARE PHYSICIANS, SURGEONS

Name: ______________________ **Address:** ______________________
Phone: ______________________ **Fax:** ______________________

Name: ______________________ **Address:** ______________________
Phone: ______________________ **Fax:** ______________________

Name: ______________________ **Address:** ______________________
Phone: ______________________ **Fax:** ______________________

Patient Signature: ______________________ Date: __________ Time: __________

Nurse/MA Signature: ______________________ Date: __________ Time: __________

Physician Signature: ______________________ Date: __________ Time: __________