(307) 682-7555
3100 West Lakeway Rd. Suite 1
Gillette, WY, 82718
highplains@vcn.com

MEDICAL HISTORY

Name _____

MEDICAL HISTORY & DATE DIAGNOSED ☐ None

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

SURGERY HISTORY & DATE PERFORMED ☐ None

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

FAMILY HISTORY OF:	YES	RELATIONSHIP
Alcohol Abuse	☐	
Anemia, low blood count	☐	
Anxiety	☐	
Arthritis / Gout	☐	
Asthma / Lung Problems	☐	
Bleeding tendency	☐	
High Cholesterol	☐	
Cancer	☐	
Breast	☐	
Ovarian/Cervical/Uterine	☐	
Colon	☐	
Prostate	☐	
Lung	☐	
Skin	☐	
Other	☐	
COPD / Lung Problems	☐	
Depression	☐	

FAMILY HISTORY OF:	YES	RELATIONSHIP
Diabetes	☐	
Diverticulosis / Diverticulitis	☐	
Epilepsy / seizures	☐	
Gallbladder disease	☐	
Glaucoma	☐	
Heart attack	☐	
Heart failure	☐	
Hepatitis / liver disease	☐	
High Blood Pressure	☐	
Inflammatory Bowel Disease	☐	
Kidney Disease	☐	
Obesity	☐	
Stroke	☐	
Thyroid Disease	☐	
Tuberculosis	☐	
Ulcer	☐	
Vascular Disease	☐	

MEDICATIONS AND DOSAGE ☐ None

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

ALLERGIES (Please Describe) ☐ None

_____

_____

SOCIAL HISTORY

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Education _____ Occupation _____

Do you drink alcohol? _____ How much? _____ How often? _____

Have you ever smoked? _____ How many years? _____ When did you quit? _____

How many packs per day do you smoke now? _____ Do you use smokeless tobacco? _____

Do you use illicit drugs? _____ What kind and how often? _____

FEMALES ONLY

Age at first menstration _____ Age at first live birth _____ # of children _____ Age of menopause _____

REVIEW OF SYSTEMS (Circle, check or "X" all that apply)

Constitutional	☐ Malaise ☐ Weakness ☐ Fever ☐ Chills ☐ Fainting ☐ Weight loss/gain ☐ Fatigue
Eyes	☐ Double vision ☐ Change in vision ☐ Blindness
Ear, Nose, Throat	☐ Difficulty hearing ☐ Congestion ☐ Nose bleeds ☐ Sore throat ☐ Dentures ☐ Runny nose
Cardiovascular	☐ Chest pain ☐ Skipped heart beat / Palpitations ☐ Shortness of breath lying flat
	☐ Leg / Ankle swelling ☐ Calf / Leg pain when walking ☐ Sweating
Respiratory	☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Sputum ☐ Bloody sputum
Gastrointestinal	☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn
	☐ Bloody / Dark bowel movements ☐ Poor appetite ☐ Difficulty swallowing / chewing
	☐ Hemorrhoids
Genitourinary	☐ Frequent urination ☐ Difficulty voiding ☐ Incontinence ☐ Painful urination
	☐ Bloody urine ☐ Kidney stones ☐ Groin hernia
Musculoskeletal	☐ Difficulty walking ☐ Arthritis ☐ Muscle weakness ☐ Back pain ☐ Neck pain
Skin	☐ Yellow skin (jaundice) ☐ Skin rash ☐ Skin problems
Neurologic	☐ Headache ☐ Dizziness ☐ Poor memory ☐ Numbness / tingling ☐ Seizures ☐ Confusion
Psychologic	☐ Stress ☐ Depression ☐ Anxiety ☐ Poor Sleeping
Endocrine	☐ Thirsty ☐ Frequent urination ☐ Cold intolerance ☐ Heat intolerance ☐ Flushing
Hematologic	☐ Easy bruising or bleeding ☐ Low blood count / Anemia
Immunologic	☐ Splenectomy ☐ HIV / AIDS ☐ Seasonal allergies
Lymphatics	☐ Swollen lymph glands

The above information is current and correct to the best of my knowledge.

Patient Signature _____

Date _____

I have reviewed the above history.

Physician Signature _____

Date _____