UNIVERSITY OF WYOMING

Albany Community Health Clinic
1174 North 22nd Street
Laramie. WY 82072

EHCW
EDUCATIONAL HEALTH CENTER OF WYOMING

Medical Information To be completed by new patients/ annually for established patients

Full Name: _____Preferred Name:_____ Date of Birth: _____

Reason for today's visit: _____

Preferred pharmacy:_____Preferred primary care provider: _____

Medications (include prescription, over the counter, herbals, supplements):

Name	Dose	How often	Name	Dose	How often

Allergies to Medications, Environment, Latex, Foods, Seasonal:

Substance	Reaction	Substance	Reaction

Do you use tobacco? (Please circle) Yes No **Do you vape?** (Please circle) Yes No

Have you used tobacco or vaped in the past? (Please circle) Yes No

What do/did you smoke/chew/vape? _____ Year started:_____ Amount:_____ pack/can/day

When did you quit?_____ How many years did you smoke/chew/vape?_____

In general, how would you rate your health? Excellent Very good Good Fair Poor

Are you currently having any pain you would like your provider to address? Yes No

Are you currently having any pain that affects your activity level? Yes No

Over the last two weeks, how often have you been bothered by the following problems? (Please check a box for each row)

	Not at all	Several days	More than half the days	Nearly every day
1. Had little interest or pleasure in doing things				
2. Been feeling down, depressed, or hopeless?				
3. Been feeling nervous, anxious or on edge?				
4. Not been able to stop or control worrying?				

Over →

Past Medical History (Please circle and write approximate year of diagnosis)**:**

Cardiovascular

Atrial Fibrillation:	Heart Disease:	Blood Clots:
High Cholesterol:	Heart Attack:	Stroke:
High Blood Pressure:	Other:	Other:

Respiratory

Asthma:	COPD:	Emphysema:
Tuberculosis:	Other:	Other:

Cancer/ blood disorders

Anemia:	Blood clotting disorder:	Lung Cancer:
Cervical Cancer:	Ovarian Cancer:	Prostate Cancer:
Colon Cancer:	Breast Cancer:	Other:

Endocrine/ Immunological

Diabetes Type 1/2:	Hypothyroidism:	Hyperthyroidism:
Lupus:	Rheumatoid Arthritis:	Other:

Eye, ear, nose, and throat

Seasonal Allergies:	Cataracts:	Glaucoma:
Chronic ear infections:	Other:	Other:

Skin

Skin Cancer: Type:	Eczema:	Other:
Psoriasis:	Other:	Other:

Musculoskeletal

Chronic pain: (back/neck/)	Osteoporosis:	Osteopenia:
Previous injury:	Other:	Other:

Gastrointestinal

Gallstones:	Cirrhosis:	Liver Disease:
GERD (heartburn):	Irritable Bowel Disease:	Celiac:
Crohn's:	Ulcers:	Other:

Kidney/ genitourinary

Enlarged Prostate:	Chronic blood in urine:	Kidney Disease:
Kidney Stones:	Chronic Urinary Infections:	Other:

Neurology/ sleep

Dementia:	Migraines:	Insomnia:
Multiple Sclerosis:	Seizures:	Peripheral Neuropathy:
Sleep Apnea:	Other:	Other:

Behavioral health

ADHD:	Alcohol Abuse:	Depression:
Bipolar Disorder:	Substance Abuse:	Hospitalization for Mental Health:
Anxiety:	Suicide Attempts:	Other:

Gynecology/ Obstetrics:

Last Menstrual Period:	Number of Pregnancies:	
Abnormal Pap Smear:	Fibroids:	Vaginitis:
Ovarian Cysts:	Other:	Other:

Infectious disease

Hepatitis:	HIV:	Gonorrhea:
Chlamydia:	Herpes:	HPV:
Syphilis:	Other:	Other:

Other Problems Not Listed: _____

Past Surgical History (Please circle and write in the approximate year)

AAA Repair:	Abdominal Surgery:	Amputation (Left/Right):
Angioplasty:	Appendectomy:	Brain Surgery:
Breast Surgery (Left/Right):	Heart Bypass:	Carpal Tunnel (Left/Right):
C-Section(s):	Colon Surgery:	Gallbladder Removal:
Gastric Bypass:	Heart Valve Surgery:	Hemorrhoid Removal:
Hernia Repair:	Hysterectomy:	Joint replacement(Left/Right):
Kidney Removal/ Transplant:	Ovary Removal:	Knee Arthroscopy(Left/Right):
Lung Surgery:	Pacemaker:	Pain Injections:
Prostate Surgery:	Rotator Cuff (Left/Right):	Spine Surgery:
Stent Placement:	Thyroid Surgery:	Tonsillectomy:
Tubal Ligation:	Urinary Incontinence Surgery:	Vasectomy:
Wisdom Tooth Removal:	Other:	Other:

Surgical Complications:_____

Family history: Please identify the family member(s) and age they were diagnosed if known (M= mother, F= father, PGM= Father's mother, PGF= Father's father, MGM= Mother's mother, MGF= mother's father, Son= son, D= daughter, Sis= Sister, B= Brother, Number multiple siblings or children ie. Sis #1) Adopted: _____Unknown: _____

Alcoholism:	Anemia:	Anesthesia Complication:
Anxiety:	Arthritis:	Asthma:
Birth Defects:	Bleeding Disorder:	Breast Cancer:
Colon Cancer:	Depression:	Diabetes:
Heart Disease:	Heart attack before 55:	Heart Attack before 65:
High Blood Pressure:	High Cholesterol:	Kidney Disease:
Lung Cancer:	Lung Disease:	Melanoma:
Mental Illness:	Migraines:	Osteoporosis:
Ovarian Cancer:	Seizures:	Severe allergies:
Stroke:	Sudden Death:	Suicide:
Thyroid Disease:	Uterine Cancer:	Other:

Over →

Social History: (Please circle)

Relationship status:

Recent change Single Dating Divorced Engaged Partnered Married Separated Widowed

Homeless: Yes No

Work and Education: Employed Unemployed Student Retired Disabled

Occupation:_____ Highest level of education:_____

Sexual History and Information: Sex at birth: Male Female Intersex

Sexual orientation: Heterosexual Homosexual Bisexual Don't know Choose not to disclose Other:

Gender identity: Male Female Transgender (male to female) Transgender (female to male) Other:

Choose not to disclose

Alcohol use: Type:_____ Amount:_____/day/week/month/year

Current alcohol problem Previous alcohol problem

How many times in the last year have you had 4 or more alcoholic beverages in one day? _____

Recreational substance use: Currently Formerly None

Type:_____ Amount:_____ /day/week/month

Current substance use problem Previous substance use problem:_____ year quit

How many times in the last year have you used an illegal drug or a prescription medication for non-medical reasons? _____

Abuse History: physical sexual emotional

Do you feel safe at home? Yes No

Preventative Care:

Exercise: Type _____ Minutes/how often _____

Healthy Diet, including fruits and vegetables: Always Sometimes Never

Seatbelt Use: Always Sometimes Never

Cancer Screening:

Women: Have you ever had a Colonoscopy? No Yes, Date:_____ Results: normal abnormal

Have you ever had a Pap test? No Yes, Date:_____ Results: normal abnormal

Have you ever had a mammogram? No Yes, Date:_____ Results: normal abnormal

Men: Have you ever had a Colonoscopy? No Yes, Date:_____ Results: normal abnormal

Have you ever had a PSA? No Yes, Date:_____ Results: normal abnormal

Any additional health information you feel may be helpful: _____

_____