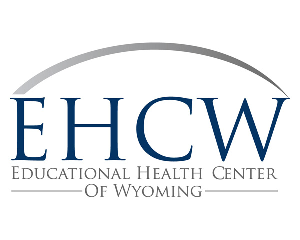
|  |  |
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| Logo_Left | |
| Albany Community Health Clinic  1174 North 22nd Street  Laramie. WY 82072  (307) 766-3313  Email: scheduling@achc.hush.com | |



**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  | Y | N |
| Do you use tobacco? |  |  |
| Do you vape? |  |  |
| Have you used tobacco or vaped in the past? |  |  |

|  |  |
| --- | --- |
| 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 have 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? |  |  |  |  |

**Personal/Biological Family Medical History:** Do you or a member of your immediate family have or have had any of the following? (Immediate Family: Father, Mother, Brothers, Sisters)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | You | | Family | | Relation |  | You | | Family | | Relation |
| Y | N | Y | N | Y | N | Y | N |
| Acid Reflux |  |  |  |  |  | Heart Attack |  |  |  |  |  |
| Allergies |  |  |  |  |  | Heart Disease\* |  |  |  |  |  |
| Anemia |  |  |  |  |  | Hepatitis |  |  |  |  |  |
| Anxiety |  |  |  |  |  | High Cholesterol |  |  |  |  |  |
| Arthritis |  |  |  |  |  | HIV/AIDS |  |  |  |  |  |
| Asthma |  |  |  |  |  | Hypertension |  |  |  |  |  |
| Atrial Fibrillation |  |  |  |  |  | Kidney Disease |  |  |  |  |  |
| Birth Defects |  |  |  |  |  | Migraines |  |  |  |  |  |
| Bleeding/Clotting Disorder |  |  |  |  |  | Osteopenia |  |  |  |  |  |
| Bowel Trouble |  |  |  |  |  | Prostate Problems |  |  |  |  |  |
| Cancer\* |  |  |  |  |  | Mental Health Problems\* |  |  |  |  |  |
| COPD |  |  |  |  |  | Seizure |  |  |  |  |  |
| Depression |  |  |  |  |  | Stroke (CVA) |  |  |  |  |  |
| Diabetes |  |  |  |  |  | Thyroid Problem |  |  |  |  |  |
| Drug Abuse |  |  |  |  |  | Other\* |  |  |  |  |  |

For items marked “Y”, please make specific comments on the lines below. IF “\*” is indicated, please specify type.

Items marked “Y”: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had surgery? If so, please specify:­ ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_