Lander Medical Clinic
745 Buena Vista Drive
Lander, WY 82520
(307) 332-2941

Western Family Care
1620 Riverview Road
Riverton, WY 82501
(307) 856-6591

ADULT MEDICAL HISTORY INFORMATION

Name: _____Male or Female Date: _____

Date of Birth: _____ Age: _____ Referred By: _____

1. State in your own words the major medical reason(s) for coming in today:

_____

2. List all of your medications including herbal medicines, inhalers, injections:

Name of Medication	Dose	When do you take it	Who prescribes it?

****Use back of sheet to provide additional medications**

3. What allergies to medications do you have and what is the reaction?

_____

_____

4. Gynecological History (Females only)

Number of pregnancies		**Last Pap Smear?**	
Number of live births		**History of Abnormal pap?**	
Last menstrual period		**History of STDs?**	
Has menopause occurred?		**Abnormal Vaginal bleeding?**	
Last Mammogram?		**Sexual dysfunction?**	

Your Major Medical Conditions:

Medical Issue	**When were you diagnosed?**	**Do you see a specialist for this? Pease list name and location**

Family History:

	Age if Living	**Age at Death**	**Major medical issues**	**Cause of death**
Mother				
Father				
Brothers				
Sisters				
Children				
Spouse				
Other				

Surgical History:

Surgeries	**Year Performed**	**Where performed**

Personal History:

Marital Status: □Single □Married □Divorced □Widowed

Education: □Grade School □Jr. High School □High School □College (2-4 years) □Graduate School

Occupation: _____

Alcohol Consumption:

Beer: □None □Occasional □ Often If often, _____ per week

Wine:□ None □Occasional □Often If often, _____ per week

Hard Liquor: □None □Occasional □Often If often, _____ per week

Have you **ever** smoked cigarettes, cigars or a pipe? □Yes □No

If you did or now smoke cigarettes, how many packs per day? _____ How many years?

Did you ever smoke more than what you currently smoke? How much? _____

If you have stopped smoking, when did you quit?_____

Health History:

When was your last colonoscopy?_____

When was your last tetanus (Tdap, Td) shot?_____

When is the last time you had routine bloodwork done?_____

Please list all other medical providers:

Medical Provider	**Specialty**	**Reason for seeing them**

PLEASE BE SURE THAT YOU HAVE FILLED OUT ALL BLANKS

Please feel free to attach any other recorded information, which you feel, will be of importance to the provider in evaluating your health problems.