5840 E. 2nd St. Suite 200
Casper, WY 82609
Telephone: 307-315-6133
Fax: 307-315-6134

Patient Health History Form

Welcome to Rocky Mountain Family Medicine. We greatly appreciate your choosing us to provide care for your family. To allow us to learn more about you, please fill out this questionnaire. For confidentiality, please fill out this form either in the waiting room prior to your visit, on our website and then bring it in before your visit or send via our secure fax server. Please do not e-mail this, completed form, as this is not a secure means of transfer for your confidential information. Once again, thank you for choosing our practice to handle your health care needs.

If you do not understand a question please mark it with a "?".
Your honesty and completeness will help us provide you with the best care possible. It is important that you answer all questions on the form. Remember, it is your health and life that is an issue. Please make every effort to have the form completed before your appointment.

First Name: _______________ Last Name: _______________ MI: ______
Date of Birth: ___________ Race: __________ Ethnicity: _______ Sex: ___
Marital Status: _______________ SSN: ____________________________
Mailing Address: ____
City: _______________ State: _______________ Zip Code: ____________
Home Number: ______________________ Cell Number: _______________
E-Mail: ____
Employer: _________________________ Work Number: _______________

Primary Insurance:
Primary Insurance Provider: _________________ Policy ID #: ___________
Name of Primary Policy Holder: ____________________________________
Date of Birth: ________________ Social Security #: __________________

Secondary Insurance:
Secondary Insurance Provider: _______________ Policy ID #: __________
Name of Secondary Policy Holder: ___________________________________
Date of Birth: _________________ Social Security #: __________________

Rocky Mountain Family Medicine LLC

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(Please Complete If Patient Is A Minor)

Who does child live with: ______________________________

Daycare/School: ______________________________

Tobacco Smoke Exposure: Yes No

Gestational age at birth: ____________ Delivery Type:______________

Birth History: ___Normal Birth ____Premature ___Complications

If complications please explain: ______________________________

Guardian Name: ________________________

Phone:______________

DOB:__________ Relationship to Child:________________________

Mailing Address:______________________City:______State:_____Zip:_______

Emergency Contact:

Emergency Contact Name: ______________________________

Phone Number: _________________ Relationship: _________________

Address: ______________________________

City:__________________State:______________Zip:______________

Preferred Contact Method: __E-Mail ___ Phone ___Mail

Have you seen Dr. Lawrence, Dr. Strand or Jane Fleming in the past? _____

Pharmacy Name:________________ Pharmacy City:______________

Reason for Doctor's Visit:

____

List any **Current Medical Problems** or **Previous Conditions:**

____

____

____

____

List any **Drug Allergies:**

____

____

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Medications (Current Prescriptions AND Over the Counter. List dose, how often taken)

____
____
____
____

List any **Past Surgeries:**

____
____
____

List **Family Medical** History**:**

Condition Relation (Mother, Father, Sibling)

____
____
____

Social History

Tobacco

Do you currently use tobacco products? ___Yes ___No

Have you used tobacco in the past? ___Yes ___No

Please describe the type of tobacco, amount consumed, dates used and frequency of use:

____

Alcohol

Do you currently drink any alcoholic beverages? ___Yes ___No

Have you used alcoholic beverages in the past? ___Yes ___No

Have you ever received a DUI or DWI? ___Yes ___No

Please describe the type of alcohol, amount consumed and how often:

____

Drugs

Do you currently use Recreational or Street Drugs? ___Yes ___No

Have you used Recreational or Street Drugs in the past? ___Yes ___No

Please describe the type of drug, amount used, dates used and frequency of use:

____

Exercise

How often do you get exercise and on average how long is each exercise session?

____