



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

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?



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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: _____

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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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: _____
Marital Status: _____ SSN: _____
Address: _____

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 #: _____