

Rocky Mountain Family Medicine Patient Health Summary

Date _____

Patient Name (please PRINT) _____

DOB _____

Allergies: None

Medication	Type of Reaction

Medication	Type of Reaction

Medications:

None What medications are you taking (including birth control pills, herbals, vitamins, dietary supplements, and over-the-counter)?

Name	Dose	How Often (once a day, twice, etc)	For what condition?

Present or Past Health Conditions:

Yes	No	Disease	Onset
		Asthma	
		Bleeding from Bowels	
		Blood Clot in Leg	
		Blood Clot in Lung	
		Congestive Heart Failure	
		Emphysema / Chronic Bronchitis	
		Gallstones	
		Heart Attack	
		Heart Murmur	
		High Blood Pressure	
		High Cholesterol	
		Irregular Heart Beat	
		Kidney Disease, Type:	
		Kidney Stones	
		Liver Disease, Type:	
		Rheumatic Fever	
		Tuberculosis	
		Ulcers in Bowel/Stomach	

Yes	No	Disease	Onset
		Anemia/Low Blood	
		Anxiety	
		Arthritis	
		Bleeding Problems, Type:	
		Blood Transfusion	
		Cancer, Type:	
		Depression	
		Diabetes/High Blood Sugar	
		Epilepsy/Seizures	
		Glaucoma	
		Gout	
		Insomnia	
		Prostate Problems	
		Skin Disease, Type:	
		Sleep Apnea	
		Stroke	
		Thyroid Problems - too high or too low	

Surgeries

Yes	No	Disease	Year
		Cataract Surgery: Left Right	
		Abdominal Surgery	
		Appendectomy	
		Broken Bone Repair	
		Gallbladder Removal	
		Heart Surgery / Catheterization	
		Joint Scope Surgery	
		Neck Artery Surgery	
		Tonsils Removed	

Yes	No	Disease	Year
		Back Disc Surgery	
		Hernia Surgery	
		Hysterectomy	
		Joint Replacement of Knee/Hip	
		Prostate Surgery	
		Vasectomy	
		Other:	

Family History

Yes	No	Disease	Relation to You
		Heart Attack	
		High Blood Pressure	
		High Cholesterol	
		Asthma	
		Tuberculosis	
		Liver Disease	
		Kidney Disease	
		Gout/Arthritis	
		Osteoporosis	
		Stroke	
		Epilepsy/Seizures	

Yes	No	Disease	Relation to You
		Bleeding Problems	
		Sickle Cell Anemia	
		Diabetes	
		Thyroid Problems	
		Cancer, Type:	
		Cancer, Type:	
		Alcohol Abuse	
		Anxiety or Depression	
		Glaucoma	
		Suicide	
		Other:	

Do you have any problems with urination? Dribbling Slow Stream Get up at night ____ times

Do you have any problems with your hearing? Yes No

When was your last eye / vision exam? _____ When was your last dental exam? _____

Other History

Exercise: Never Rarely Other:

When was your last:

Tetanus:	<input type="checkbox"/> Never	Hepatitis B:	<input type="checkbox"/> Never	Pneumovax:	<input type="checkbox"/> Never
Flu Shot:	<input type="checkbox"/> Never	Hepatitis A:	<input type="checkbox"/> Never	Gardasil:	<input type="checkbox"/> Never
Shingles Vaccine:	<input type="checkbox"/> Never				

Smoking/Tobacco Use:

Have you ever smoked? Yes No

How many years did you smoke? _____

When did you quit? _____

How many packs per day do you smoke now? _____

Do you use smokeless tobacco? Yes No For how many years: _____

Eye Exam by Eye Doctor:	<input type="checkbox"/> Never
Hearing Test:	<input type="checkbox"/> Never

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol/Drugs:

Yes No Do you drink? How much? _____ How Often? _____

Yes No Do you use drugs? How much? _____ How Often? _____

What kind? _____

What drugs have you used in the past? _____

Female Patients Only

of Pregnancies: **# of Deliveries:** **# of Elective Abortions:** **# of Miscarriages:**

When was your last menstruation? _____ How old were you when you went through Menopause? _____

When was your last Pap Smear? _____ Have you ever had an abnormal Pap Smear? Yes No

If 'Yes', when was the abnormal Pap smear? _____

What was the abnormality? _____

What kind of treatment did you have? _____

When was your last Mammogram? _____ Have you ever had an abnormal Mammogram? Yes No

If 'Yes', when was the abnormal Mammogram? _____

When was your last Bone Density Screening Test? _____ Was it normal? Yes No

The above information is current and correct to the best of my knowledge.

Patient/Guardian Signature Date

_____ Provider Signature	_____ Date
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