CODY CLINIC

2107 Sheridan Ave, Cody, WY 82414 • P: (307) 586-5303 • F: (307) 586-5304

New Patient Form

Patient Name: _____
(*LAST*) (*FIRST*)

Birthdate: _____/_____/_____ Age: _____ Gender: _____

Marital Status: _____ Ethnicity: _____

Street Address: _____ City, State, Zip: _____

Primary Phone: _____ Alternative Phone: _____

Email: _____

Who may we thank for referring you? _____

Current Medical Concerns:

_____

_____

_____

_____

Social History:

Tobacco Use: [ ] Current [ ] Former [ ] Smokeless tobacco

If Former, when did you quit? _____ Alcohol Use: _____

Recreational drug use: _____ If Yes, what? _____

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Past Medical History

[ ] COPD	[ ] Thyroid Disorder	[ ] Depression	[ ] Asthma
[ ] High Blood Pressure	[ ] Stomach Ulcers	[ ] Anxiety	[ ] Congestive Heart
[ ] High Cholesterol	[ ] HIV/AIDS	[ ] Stroke	Failure
[ ] Heart Disease	[ ] Anemia	[ ] Blood Clots	[ ] Irregular Heartbeat
[ ] Heart Stents	[ ] Aneurysm	[ ] Arthritis	[ ] Cancer:
[ ] Diabetes	[ ] Sleep Apnea	[ ] Colitis	which kind?
[ ] Kidney Disease	[ ] Osteoporosis	[ ] Colon Polyps	_____

List all surgeries and hospitalizations:

Medications (Prescribed, over the counter, vitamins and supplements)

Medication	Dose (Strength & Quantity)	How long have you taken?

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Family History:

	Age	Deceased? Cause of Death?	Circle all that apply: (Blood relatives only: Parents, grandparents, siblings)			
				Relationship		Relationship
Father			Asthma		Heart Disease	
Mother			Blood Clots		Liver Disease	
Brothers			Cancer		Osteoarthritis	
			Diabetes		Osteoporosis	
			Emphysema		Stroke	
Sisters			High Blood Pressure		Thyroid Disease	
			High Cholesterol		Tuberculosis	
Children						

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Allergies: _____

Local Pharmacy: _____ Phone: _____

Mail Order Pharmacy: _____ Phone: _____

Fax: _____

Health Maintenance: When were these last performed? Normal or Abnormal results?

Mammogram: _____

Pap Smear: _____

Colonoscopy: _____

Bone Density Scan (DEXA): _____

Immunizations: List date of last vaccine.

Influenza: _____ Zostavax (Shingles): _____

Pneumovax 23: _____ Tetanus/Pertussis: _____

Prevnar 13: _____

Insurance Information:

Primary Insurance: _____ Subscriber: _____

Subscriber DOB: ___/_____/_____Policy #: _____ Group #: _____

Address: _____ Phone: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Address: _____ Phone: _____

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System Breakdown:

(Check all that apply)

Constitutional:
- ☐ Appetite change
- ☐ Excessive sweat
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss
  Amount _____

Eyes:
- ☐ Irritation/Pain
- ☐ Discharge
- ☐ Redness

ENT:
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ Dizziness
- ☐ Facial pain
- ☐ Runny Nose
- ☐ Nasal Congestion
- ☐ Nosebleeds
- ☐ Bleeding gums
- ☐ Dental pain
- ☐ Mouth Lesions
- ☐ Hoarseness
- ☐ Sore throat

Cardiovascular:
- ☐ Chest pain
- ☐ Decreased exercise tolerance
- ☐ Short of breath with activity
- ☐ Short of breath at rest
- ☐ Irregular heartbeat
- ☐ Fainting spells
- ☐ Pain in legs
- ☐ Swelling in legs
- ☐ Leg ulcers

Respiratory:
- ☐ Cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Chest pain while breathing
- ☐ Wheezing
- ☐ Excessive snoring
- ☐ Stop breathing at night

Gastrointestinal
- ☐ Stomach pain
- ☐ Bloating
- ☐ Food intolerance
- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abnormal stool

Genitourinary:
- ☐ Painful urination
- ☐ Bloody urine
- ☐ Frequent/urgent urination

Musculoskeletal:
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle aches

Integumentary:
- ☐ Hair changes
- ☐ Abnormal moles
- ☐ Nail changes
- ☐ Pigment changes
- ☐ Itching/rashes
- ☐ Breast masses
- ☐ Nipple discharge

Neurological:
- ☐ Headaches
- ☐ Migraines

Endocrine:
- ☐ Abnormal menstruation
- ☐ Excessive thirst
- ☐ Increased appetite

Psychiatric:
- ☐ Anxiety
- ☐ Deceased concentration
- ☐ Irritability
- ☐ Panic attacks
- ☐ Sleep disturbance
- ☐ Sadness/tearful

Hematologic/Lymphatic
- ☐ Easy bruising
- ☐ Bleeding tendency
- ☐ Swollen/tender glands
- ☐ Susceptible to infection

Allergy/Immunologic
- ☐ Eczema
- ☐ Seasonal allergies
- ☐ Hives

Women only:

Age when periods began: _____

Regular periods: _____

Last period? _____/_____/_____

Number of pregnancies? _____

Number of miscarriages? _____

Birth control? _____

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Emergency Contact:

Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Relationship: _____

Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Relationship: _____

Signature: _____ **Date**: _____