Internal Medicine Group
2301 House Avenue, Suite 300
Cheyenne, WY 82001
Fax 307-638-2656 Phone 307-635-4141 www.imgwy.com

Form B

Past Medical History Form

Patient Name_____ **Referring Doctor**_____

Date of Birth_____ **Primary Doctor**_____

Mark all that apply:

Childhood Illness:

- ❍ Rheumatic Fever
- ❍ Epilepsy
- ❍ Asthma
- ❍ Measles/Mumps/Chicken Pox
- ❍ Other

Adult Illness:

- ❍ High Blood Pressure
- ❍ Diabetes
- ❍ Heart Disease
- ❍ Stroke
- ❍ Thyroid
- ❍ COPD/Emphysema/Other Lung Diseases
- ❍ Cancer (specify type)
- ❍ Intestinal/Stomach
- ❍ Liver disease
- ❍ Arthritis
- ❍ Others

Surgery:

- ❍ Heart
- ❍ Chest
- ❍ Gallbladder
- ❍ Hysterectomy/Ovaries
- ❍ Orthopedic
- ❍ Others

Medications, including dose and schedule:

_____ _____

_____ _____

_____ _____

_____ _____

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Patient Name_____

Date of Birth_____

Allergies:

Medication: _____

Food: _____

Environmental: _____

Other: _____

Family History:

- ❍ Heart disease/Stroke
- ❍ High blood pressure
- ❍ Diabetes
- ❍ Thyroid
- ❍ Cancer
- ❍ Others

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation/Job_____

Occupational Hazards/Exposure_____

Do you have children?_____ If so, how many?_____ Ages_____

Habits:

- ❍ Tobacco (smoke or chew)
- ❍ Alcohol
- ❍ Coffee/Tea/Soda (caffeinated/non-diet)
- ❍ "Street Drugs"

Foreign Travel:

- ❍ Asia
- ❍ Africa
- ❍ South America
- ❍ Central America
- ❍ Others

History of Blood Transfusions?

- ❍ Yes
- ❍ No

Blood/Plasma Donation?

- ❍ Yes
- ❍ No