St. Johns Lander Clinic
175 N. 1st Street
Lander, WY, 82520
(307) 332-2189

DATE	NAME	DATE OF BIRTH

PREFERRED PHARMACY		ALLERGIES	

REASON FOR VISIT	

MEDICATION/SUPPLEMENT	DOSE	FREQUENCY

PROBLEM	Yes/ No	YEAR
ANESTHESIA INTOLERANCE	Y / N	
AUTOIMMUNE		
Lupus / RA / Chronic steroid use	Y / N	
CANCER		
If yes, Type:	Y / N	
CARDIAC		
High / Low Blood pressure	Y / N	
Heart Attack / Failure / Cardiac Stent / CABG	Y / N	
Swelling / Murmur / High Cholesterol	Y / N	
EYE		
Blindness / Blurry Vision / Cataracts / Glaucoma	Y / N	
ENT		
Seasonal Allergies / Sinus Problems or Drainage	Y / N	
Ear Problems / Hearing Loss	Y / N	
Throat Issues / Mouth Issues / Dental Issues	Y / N	
ENDOCRINE		
Diabetes / Thyroid Issues / Cushing's / Addison's	Y / N	
FEVER / FATIGUE	Y / N	
GASTROINTESTINAL		
Ulcer / GERD / Diarrhea / Vomiting	Y / N	
Diverticulitis / IBS / UC / Crohn's / Blood in Stool	Y / N	
HEMATOLOGIC		
Anemia / Blood Transfusions / Sickle Cell	Y / N	
Blood Clots / Blood Thinners	Y / N	
HOT FLASHES / NIGHT SWEATS	Y / N	

PROBLEM	Yes/No	YEAR
KIDNEY / BLADDER		
Kidney Failure or Disease / STONES	Y / N	
UTI / Prostate / Retention / Catheter	Y / N	
LIVER		
Failure / Cirrhosis / Jaundice / Pancreatitis	Y / N	
LUNG		
Cough / Asthma / COPD / Sleep Apnea / Oxygen	Y / N	
MUSCULOSKELETAL		
Arthritis / Gout / Osteopenia / Trauma	Y / N	
NEUROLOGICAL		
CVA / TIA / Headaches / Seizures / TBI / MS /Insomnia	Y / N	
PSYCHIATRIC		
Anxiety/Depression / ADHD / Bipolar /Schizophrenia	Y / N	
OB / GYN		
Number of Pregnancies_____	Y / N	
Number of Live Births_____	Y / N	
PID / Endometriosis / PCOS / Infertility	Y / N	
SKIN CONDITIONS	Y / N	
Type:		
OTHER		

HOSPITALIZATIONS AND SURGERIES					
REASON	**HOSPITAL**	**YEAR**	**REASON**	**HOSPITAL**	**YEAR**

SUBSTANCE	USE	FREQUENCY	AMOUNT
Alcohol	Never Current Past	Daily Weekly Monthly	
Smoke Tobacco	Never Current Past	Daily Weekly Monthly	
Smokeless Tobacco	Never Current Past	Daily Weekly Monthly	
E Cig or Vape	Never Current Past	Daily Weekly Monthly	
Marijuana	Never Current Past	Daily Weekly Monthly	
Cocaine	Never Current Past	Daily Weekly Monthly	
Amphetamines	Never Current Past	Daily Weekly Monthly	
Hallucinogens	Never Current Past	Daily Weekly Monthly	

SCREENING	MONTH/ YEAR	ABNORMAL FINDINGS
Colonoscopy		
Prostate Exam (men)		
PAP SMEAR (women)		
MAMMOGRAM (women)		
Sexually Transmitted Infections		
Dexa scan		
Pain Contract		

EXERCISE	HOURS PER WEEK
Walking	
Running	
Cycling	
HIIT	
Yoga	
Weightlifting	
Other	

PREGNANT (circle one)	**YES** (If yes, estimated due date is _____ / **NO** / **POSSIBLE** / **NA**

How often have you been bothered by the below symptoms over the last two weeks?				
Little interest or pleasure in doing things	Not at all	More than half the days	Several days	Nearly every day
Feeling down, depressed, or hopeless	Not at all	More than half the days	Several days	Nearly every day

FAMILY HISTORY	LIST MAJOR MEDICAL HISTORY	LIVING	AGE OF DEATH
MOTHER		Y / N	
FATHER		Y / N	
MATERNAL GRANDMOTHER		Y / N	
MATERNAL GRANDFATHER		Y / N	
PATERNAL GRANDMOTHER		Y / N	
PATERNAL GRANDFATHER		Y / N	
BROTHER / SISTER		Y / N	
BROTHER / SISTER		Y / N	
BROTHER / SISTER		Y / N	

FOR CLINIC USE						
BP			**VISION**			
O2				**L**	**R**	**B**
HR			**CORRECTED**			
RR			**UNCORRECTED**			
TEMP						
HT			**LMP**			
WT			**BIRTH CONTROL**			