

WIND RIVER ONCOLOGY

1035 Rose Lane, Suite D
Riverton, WY 82501
(307) 856-4688

PATIENT NAME: _____

PATIENT MEDICATIONS

MEDICATION NAME	DOSE	HOW OFTEN DO YOU TAKE THIS MED?	HOW LONG HAVE YOU BEEN TAKING THIS?	PRESCRIBING PHYSICIAN

ALLERGIES: _____

PAST ILLNESS (Please check all that apply and indicate Self, Father, Mother or Siblings)

ANEMIA		KIDNEY FAILURE	
ANGINA		KIDNEY STONES	
ARTHRITIS		LUPUS	
ASTHMA		LYME DISEASE	
BLOOD CLOTS		MULTIPLE SCLEROSIS	
CHRONIC BRONCHITIS		OSTEOPOROSIS	
COLITIS		OTHER COLLAGEN VASCULAR DISEASES	
CROHN'S DISEASE		PANCREATITIS	
CYSTITIS OR BLADDER INFECTION		PARKINSON'S DISEASE	
DEPRESSION		PSYCHIATRIC TREATMENT	
DIABETES		RHEUMATOID ARTHRITIS	
DIVERTICULAR DISEASE / Polyp		SCLERODERMA	
EMPHYSEMA		SEIZURES OR EPILEPSY	
GALLBLADDER DISEASE		SEVERE ANXIETY	
GYN PROBLEMS OR INFECTIONS		SKIN CONDITIONS	
HEART ATTACK		STROKE OR PARALYSIS	
HEART FAILURE		THYROID DISEASE	
HEART MURMUR		TUBERCULOSIS	
HEPATIC OR LIVER DISEASE		ULCERS (STOMACH)	
HIATAL HERNIA		WEST NILE VIRUS	
HIGH BLOOD PRESSURE		CANCER (LIST TYPE OF CANCER BELOW)	
HUMAN IMMUNE VIRUS (HIV)			
IRREGULAR HEART BEAT			

ADDITIONAL INFORMATION

Transportation Problems? Y N Comment: _____
Financial Concerns? Y N Comment: _____
Other problems or special needs: _____

ADVANCE DIRECTIVE (LIVING WILL) We are required by the State to inquire:

Do you have an Advance Directive? Y N
If yes, would you provide us with a copy for your medical record? Y N
Staff who received copy for medical record: _____ Date: _____
If you don't have an Advance Directive, would you like the information? Y N

WORK HISTORY

Occupation: _____
Still working? Y N
If yes, has your job changed due to illness? Y N
Were you exposed to carcinogenic substances, asbestos? Y N
Has your illness forced you to stop working? Y N
Do you anticipate being off work? Y N
Has your illness forced significant others to stop working? Y N
Has your illness forced significant others to change hours? Y N
Have you applied for disability? Y N
Comment: _____

HISTORY OF TOBACCO, ALCOHOL AND DRUGS

Tobacco

Ever use tobacco? Y N How many packs per day? _____
Currently use tobacco? Y N What age started? _____
If yes, check type(s): Cigarettes _____ Pipe _____ Snuff _____ Chew _____
Would you like information on how to quit smoking? Y N

Alcohol

Ever use alcohol? Y N If yes, list type: _____
Currently use alcohol? Y N What age started? _____
Drink socially? Y N What age stopped? _____