



**Midlands Family Medicine**  
 611 West Francis Street, Suite #100  
 North Platte, NE 69101  
 Phone: 308-534-2532  
 Fax: 308-534-6615

**Family Medical Center**  
 221 East 10<sup>th</sup> Street  
 Ogallala, NE 69153  
 Phone: 308-284-8421  
 Fax: 308-284-2821

Website: [Midlandshealthcare.com](http://Midlandshealthcare.com)

## PATIENT INTAKE AND HISTORY FORM

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Preferred Local Pharmacy:** \_\_\_\_\_  
(Address/City)

Do you use a mail order pharmacy? \_\_\_\_\_ If so, please be sure we have your pharmacy provider information and a copy of your prescription drug card.

**Preferred Mail Order Pharmacy:** \_\_\_\_\_

**\*\*\*Should your information change, please report these changes in your address, phone contact numbers, insurance, or emergency contact, information to the front desk upon check in at future visits\*\*\***

Reason(s) for coming to the doctor today:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Has a previous Provider provided treatment for the reason you are being seen today?

If yes, please provide Provider information. \_\_\_\_\_

- Do you currently **follow up with any other Provider/Specialist?** (Example: Cardiology, Neurology, Urology, Endocrinology, Infection disease, Mental Health, Nephrology, Therapy, Optometry, Orthopedics, ENT.)

If so please list the provider(s) you are following up with:

\_\_\_\_\_

\_\_\_\_\_

**Healthcare Maintenance Screening** (please list the most recent date if applicable)

	Date completed	Who and Where performed or administered?
Date of Colonoscopy:		
Date of Mammogram:		
Date of Last Pneumonia shot: Pneumovax 23 or Prevnar		
Date of Last Flu shot:		
Date of Last Eye Exam:		
Date of Last Bone Density Study (DEXA):		
Date of Last Pap Smear:		
Date of Last Tetanus Shot:		
Date of Last Zostavax (Shingles Vaccine):		

**Problem List/Past Medical History:**

Have you been diagnosed with any of the following (currently or in the past)?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abdominal Pain             | <input type="checkbox"/> GERD                    | <input type="checkbox"/> Prostate Disease             |
| <input type="checkbox"/> Abnormal Vaginal Bleeding  | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Rash                         |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Headaches, Chronic      | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Rubella                      |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Scarlet Fever                |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Heart Palpitations      | <input type="checkbox"/> Seasonal Allergies           |
| <input type="checkbox"/> Back Pain                  | <input type="checkbox"/> Hemorrhoids             | <input type="checkbox"/> Seizure                      |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Sinusitis                    |
| <input type="checkbox"/> Colitis, Ulcerative        | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Sleep Disorder               |
| <input type="checkbox"/> COPD                       | <input type="checkbox"/> Incontinence            | <input type="checkbox"/> Somnolence                   |
| <input type="checkbox"/> Crohn's                    | <input type="checkbox"/> Irritable Bowel         | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Deep Vein Thrombophlebitis | <input type="checkbox"/> Kidney Stone(s)         | <input type="checkbox"/> Tendinitis                   |
| <input type="checkbox"/> Dementia                   | <input type="checkbox"/> Measles                 | <input type="checkbox"/> Thyroid Disorder             |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Migraines               | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> MRSA Infection          | <input type="checkbox"/> Ulcer                        |
| <input type="checkbox"/> Diverticulitis             | <input type="checkbox"/> Mumps                   | <input type="checkbox"/> Urinary Frequency            |
| <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Urinary Pain                 |
| <input type="checkbox"/> ED (erectile dysfunction)  | <input type="checkbox"/> Polio                   | <input type="checkbox"/> Vascular Disease, Peripheral |
| <input type="checkbox"/> GI Bleed                   | <input type="checkbox"/> Guillain Barre Syndrome |   |

List any other important **medical condition(s)** and or **Surgeries** you have had (do not include common colds or flu). Include date or age of initial diagnosis/surgery if possible: (continue on back if necessary)

*Problem/Previous Diagnosis*

*Date(s) or Age*

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**Allergy History:**

List known allergies (including medication allergies) and reaction to allergen. Or check one of the boxes below:

- No Known Allergies (NKA)                       No Known Drug Allergies (NKDA)

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**Medication History:**

List any medications and vitamins/minerals/herbs that you are currently taking.

Ensure to **include Name, Dose, and Frequency of medication(s)**. or Bring Medication Bottles or Completed List with you to appointment.

No Current Meds

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**Social History:**

Do you use tobacco products? Never used Former use Current use Unknown  
How often? Rare Social Daily  
What type? Cigarettes Chewing Tobacco Cigars

Are you exposed to "second-hand" smoke? Yes No  
If yes, please indicate by marking the appropriate boxes: Minimal Frequent Daily  
Family members smoke indoors Family members smoke outdoors only

Please describe your current exercise routine: Inactive Light Moderate Vigorous

Do you drink beverages with caffeine? Yes No  
What type? Coffee Tea Carbonated Beverages

Have you ever used any illicit drugs? Yes No  
How often? Quit Social Use Regular Use Daily Use  
What type? Uses marijuana Uses cocaine Uses methamphetamines

Do you drink beverages with alcohol? Yes No  
How often? Occasional use Moderate use Heavy use  
What type? Beer Hard Liquor Wine

What is your most recent primary occupation? \_\_\_\_\_



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**Family History:**

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)?

	<b>Father</b>	<b>Mother</b>	<b>Father's Father</b>	<b>Mother's Mother</b>	<b>Sister</b>	<b>Brother</b>	<b>Son</b>	<b>Daughter</b>
Heart Disease	_____	_____	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____	_____
Epilepsy/Convulsions	_____	_____	_____	_____	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____	_____	_____

List any other important family medical condition(s) you are aware of (do not include common colds or flu). Include date of initial diagnosis if possible:

*Family member*

*medical condition*

**Diagnostic Studies:** (mark only those that apply)

<b>Dignostic Study</b>	<b>Date Performed</b>	<b>Who and Where Study performed</b>
Angiography (Heart Catheterization):		
Cardiac Stress Test:		
Cardiac Echocardiogram:		
EKG:		
EGD:(esophagogastroduodenoscopy)		
EEG: (electroencephalogram)		
Pulmonary Function Test (PFT):		
Sleep Study:		
Spirometry:		