St John's Internal Medicine and Cognitive Health
PO Box 4010 555 East Broadway Ste 229
Jackson, Wyoming 83001
(307) 739-7434

I have an appointment with Dr. Stearn for: (circle one) Cognitive Health Internal Medicine

NAME:_____ DOB:_____ DATE:_____

CURRENT COMPLAINT OR CONCERN _____

CURRENT MEDICATIONS

Medication	Dose/Frequency	Medication	Dose/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES TO MEDICATIONS OR FOODS_____
_____

PAST MEDICAL HISTORY (Circle all that apply)

Anemia/Blood Transfusions	Depression/Anxiety	High/Low Blood Pressure	Psychiatric Care
Arthritis	Diabetes/Pancreatitis	High Cholesterol	Seizures
Asthma/Emphysema	Diarrhea/Colitis/Crohn's	Kidney Problems	Seasonal Allergies
Blood Clots/Anti-Coagulation	Dementia	Liver Problems/Hepatitis	Steroids/Immunosuppression
Blood in Stool	Headaches/Migraines	Lung Problems/Cough	Stroke/Neurologic Deficits
Cancer/Concerning Masses	Heartburn/Gastric Ulcers	Mental Illness	Thyroid Problems
Concussion	Heart Attack/ Failure	Rashes	Urinary Problems
Coughing up Blood	Heart Disease/Murmur/Angina		

Other:_____

PAST HOSPITALIZATIONS AND SURGERIES

Reason	Hospital/Year	Reason	Hospital/Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date of last Colonoscopy _____ Results_____

FOR MEN ONLY

Date of last Prostate Exam _____ Results_____

FOR WOMEN ONLY Date of last PAP Smear _____ Last MAMMO_____
How many Pregnancies? _____ # of Living Children _____
Have you ever had a breast biopsy? Yes / No Results_____

IMMEDIATE FAMILY HISTORY (Circle All That Apply)

Alcoholism	Dementia	Heart Disease	Rheumatoid Arthritis
Breast Cancer	Depression	High Blood Pressure	Stroke
Colon Cancer	Diabetes	Mental Illness	Family History Unknown

Other Cancer (list type)_____

SOCIAL HISTORY

Do you drink alcohol?	Yes / No	If yes, how often?	_____
For how many years	_____	How much per session?	_____
Do you currently use tobacco	Yes / No	Packs per day	_____
For how many years	_____	Quit Date	_____

Have you experienced any alcohol or substance abuse withdrawals? Yes / No

IMMUNIZATIONS

Have you had the Pneumococcal Pneumonia Vaccine	Yes / No
Date of last Tetanus Shot	_____
Date of last Zostavax (Shingles) Vaccine	_____
Have you had a flu shot this year	Yes / No
Date of last TDAP Vaccine	_____