Infectious Disease

2301 House Ave., Suite 201 • Cheyenne, WY 82001 • (307) 638-7757 • cheyenneregional.org

Patient Name ______________________________________Date: ____________________

Provider you will be seeing: ____

PLEASE ARRIVE AT ________________FOR YOUR CHECK-IN TIME

Appointment Date: ____

To assist us in providing the best care possible, we ask for your assistance in the following areas:

1. Please ask your referring provider to send any records, labs, radiology reports, etc. that may pertain to their referral.
2. Please show up **AT YOUR CHECK-IN TIME** for your appointment so our front office staff will be able to check you in in timely manner. **Patients that are more than 10 minutes late may be rescheduled to a later time or date.**
3. Please bring a list of your current medications, prescribed and over the counter.

Please bring your **Insurance Card**, **Copayment** and a **Photo ID.**

If you do not have Medical Insurance or CRMC Charity Care your **NEW PATIENT VISIT DEPOSIT IS $180.00** and your **FOLLOW UP VISIT DEPOSIT IS $120.00.** This is required at the time of service and is not the total cost of your appointment.

We look forward to seeing you soon. If you have any questions or need to reschedule your appointment, **please call the office at 307-638-7757.**

Thank you,

The Medical Specialty Clinic Staff

Medical Specialty Clinic: Infectious Disease

Patient Name: ___________________________________ Date of Birth: _______________ Today's Date: _______________

Patient History Questionnaire

History of Present Illness

Location: ____
(Where on the body symptoms occur)

Duration: ____
(How long do symptoms last)

Severity: ____
(On a Scale of 1-10, 1 being no pain & 10 being worst pain imaginable)

Quality: ____
(Character of symptom / stabbing, burning, gnawing, sharp, itching)

Timing: ____
(When do symptoms occur? After meals, exercise, etc.?)

Context: ____
(Situation associated with symptoms / Touch, Pressure, Cold, Heat)

Modifying Factors: _________________________________
(Things that make symptoms better or worse)

Signs / Symptoms: ___________________________________
(Other things that happen when symptoms occur)

Medical History (Please circle YES or NO if you have any of the following medical problems)

High Blood Pressure	YES	NO	Diabetes	YES	NO	Heart Problems	YES	NO
Respiratory Problems	YES	NO	Stroke	YES	NO	Cancer	YES	NO
Sleep Problems	YES	NO	Bleeding	YES	NO	HIV/AIDS	YES	NO

Other Problems: ____

Surgical History

Do you have any hardware (example: hip or knee replacement, pacemaker): NO YES If yes, please fill out the following:

What: ____ Date: ____

What: ____ Date: ____

Other Surgeries:

What: ____ Date: ____

What: ____ Date: ____

Most Recent Hospitalization:

Reason: ____ Date: ____

Medications

Medication	Dosage	Frequency

Medication Allergies	Reaction

Family History (Please List Any Medical Problems with Your Relatives)

Family Member	Medical Problem
Father	
Mother	
Siblings	
Other	
Other	

Social History (Circle All That Apply)

Tobacco use: NEVER / FORMER (Quit Date: __________) / YES (Type: _____________ Packs per Day: ______________)
Alcohol Use: NO / YES (Type:______________________________ How Much per Day / Week / Month: __________)
Occupation: ____

Other

Have You Traveled Outside of the U.S.: NO YES If Yes, Where Did You Travel: _________________________________
Have You Traveled Within the U.S.: NO YES If Yes, Where Did You Travel: _________________________________

Do You Have Any Pets At Home: NO YES If Yes, What Kind: ____
Are You Living or Working on a Ranch or Farm: NO YES
Current Hobbies: ____

Vaccination History

Did You Receive the Usual Childhood Vaccinations: NO YES
Did You Receive a Yearly Influenza Vaccination: NO YES
Have You Received a Pneumonia Vaccination: NO YES If Yes, When: ____________________________________

Advanced Directives

Do You Have Advanced Directives: NO YES
Do You Have a Living Will: NO YES
Do You Have a Designated Durable Power of Attorney for Health Care: NO YES If Yes, Their Name: ________________

Review of Symptoms

Constitutional

Good General Health	NO	YES
Recent Weight Changes	NO	YES
Night Sweats / Fever	NO	YES
Fatigue	NO	YES

Eye

Wear Glasses / Contacts	NO	YES
Blurred / Double Vision	NO	YES
Eye Disease or Injury	NO	YES

Cardiovascular

Chest Pain	NO	YES
Palpitations	NO	YES
Heart Disease	NO	YES
Swelling of Hands / Feet	NO	YES

Musculoskeletal

Muscle Pain or Cramps	NO	YES
Stiffness / Swelling Joints	NO	YES
Joint Pain	NO	YES
Trouble Walking	NO	YES

Endocrine

Excessive Thirst / Urination	NO	YES
Thyroid Disease	NO	YES
Hormone Problems	NO	YES

Gastrointestinal

Nausea / Vomiting	NO	YES
Abdominal Pain	NO	YES
Rectal Bleeding	NO	YES
Bowel Problems	NO	YES
Heartburn	NO	YES

Integumentary (Skin / Breast)

Change in Hair or Nails	NO	YES
Rashes or Itching	NO	YES
Breast Lumps	NO	YES
Breast Pain or Discharge	NO	YES

Ears / Nose / Mouth / Throat

Hearing Loss or Ringing	NO	YES
Sinus Problems	NO	YES
Nose Bleed	NO	YES
Sore Throat / Voice Change	NO	YES

Respiratory

Shortness of Breath	NO	YES
Cough	NO	YES
Wheezing / Asthma	NO	YES
Coughing Up Blood	NO	YES

Neurological

Frequent Headaches	NO	YES
Paralysis or Tremors	NO	YES
Seizures	NO	YES
Numbing / Tingling	NO	YES

Hematologic / Lymphatic

Bruise Easily	NO	YES
Slow to heal	NO	YES
Enlarged Glands	NO	YES

Genitourinary

Blood in Urine	NO	YES
Kidney Stones	NO	YES
Sexual Problems	NO	YES
Menstrual Problems	NO	YES
Testicle Pain	NO	YES

Psychiatric

Insomnia	NO	YES
Confusion / Memory Loss	NO	YES
Depression	NO	YES
Tired / Fatigued	NO	YES

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signature: ____ Date: _________________

Cheyenne Regional
Medical Group
Medical Specialty Clinic

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CANCELLATION AND MISSED APPOINTMENT/NO SHOW PROCEDURE

Dear Valued Patient,
Our goal is to provide timely quality medical care. No-Shows and late cancellations inconvenience those who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for all our patients.

CANCELLATION OF AN APPOINTMENT
In order to be respectful of the medical needs of other patients, please be courteous and call the Medical Specialty Clinic promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

HOW TO CANCEL YOUR APPOINTMENT
To cancel an appointment, please call (307) 638-7757. If you do not reach the receptionist, you may leave a detailed message on our voicemail. Please leave your name and phone number and we will return your call to give you the next available appointment time.

LATE CANCELLATION
A late cancellation is someone who does not cancel their appointment before 24 hours of their scheduled appointment time.

NO-SHOW PROCEDURE
A “no-show” is someone who fails to arrive for a scheduled appointment without cancelling the appointment prior to the scheduled time.

- First no show: There will be no charge
- Second no show: May result in a $25 fee billed to your account
- Third no show: May result in an additional $25 fee billed to your account and dismissal from our practice.

I have read and understand the Medical Specialty Clinic Cancellation and Missed Appointment/No Show Procedure.

______________________________	______________________
Patient Printed Name	Date of Birth
______________________________	______________________
Patient Signature	Today’s Date

The Medical Specialty Clinic values you as a patient and strives to provide you with excellent medical services! Thank you for your support of this process.