Jennifer Rasmuson, NP-C
1301 Avon St. Ste A, Sheridan, WY 82801
66 W. Angus St., Buffalo, WY 82834
Office: 307-752-8136
Fax: 307-785-1096

New Patient Intake
CHILD (5-18)

Patient Information:

Name:_____DOB:_____SS Number:_____

Child lives with: Mother_____ Father_____ Both_____

Mother's Name:_____ DOB:_____Phone:_____

Address:_____

Father"s Name:_____ DOB:_____Phone:_____

Address:_____

Insurance:

Insurance Provider:_____Member ID:_____

Group Number:_____Primary Subscriber:_____DOB:_____

Insurance Co. Address (on back of card):_____

Preferred Pharmacy:_____

Allergies:_____

Current Medications: _____

Please list your current health Concerns:

_____

_____

Surgery/Hospitalization:

_____

_____

Immunization Up To Date: Yes_____ No_____ None:_____

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Personal History/Review of Systems:

General: Fatigue_____ Weight Change_____ Migraines _____

Respiratory: Asthma_____ Seasonal Allergies _____

Cardiovascular: High BP_____ Chest pain_____ Irregular HR_____

History of Blood Clots/Blood Disorders_____

Gastrointestinal: Constipation_____ Loose Bowels_____ Gas/bloating_____ Heartburn_____

Urinary: Hx of frequent UTIs_____ Incontinence_____ Blood in urine_____

Muscular/Skeletal: Joint pain_____ Muscular pain_____Stiffness/swelling_____

Numbness/Tingling_____

Females:

Age menstruation began:_____Heavy flow: Yes_____ No_____

Birth Control_____ Method/Medication Name_____

Frequent yeast infections_____ Frequent UTI's _____

Family History:

Please indicate the following: M=Mother F=Father S=Sister(s) B=Brother(s) G=Grandparent(s)

Blood Disorders_____ Anemia_____ Hemophilia_____

Alcohol/Drug Abuse_____

Cancer_____Type:Colon_____Breast_____Lung_____Other_____

Diabetes_____Thyroid Disorder_____Other Autoimmune Disease_____

Heart Disease:_____ High Blood Pressure_____ High Cholesterol_____

Mental Illness_____ Suicide_____ Dementia_____