KootenaiClinic

Comprehensive Patient History Form

Date:__________________________

Name:____ D.O.B._________________________

Past Medical History: *(check all that apply)*

☐ Acid Reflux
☐ Alcohol or Drug Problem
☐ Allergy problems
☐ Anemia
☐ Artery/Vein problems
☐ Arthritis
☐ Asthma
☐ Autoimmune disease
☐ Bleeding problems
☐ Blood clots
☐ Cancer
☐ Cataracts
☐ Colitis/Crohns
☐ Chronic pain
☐ Depression, Anxiety
☐ Diabetes
☐ Esophagitis, ulcers
☐ Fractures
☐ Gallstones
☐ Glaucoma
☐ Gout
☐ Headaches
☐ Heart disease
☐ Heart valve problems
☐ Hernia
☐ High blood pressure
☐ High cholesterol
☐ HIV
☐ Irritable bowel
☐ Kidney disease
☐ Kidney stones
☐ Liver disease/Hepatitis
☐ Lung disease
☐ Migraines
☐ Mental Health Diagnosis
☐ MRSA
☐ Osteoporosis
☐ Recurrent skin infections
☐ Recurrent UTI
☐ Seizures
☐ Sexually transmitted Infections
☐ Sleep Apnea
☐ Stroke
☐ TB
☐ Thyroid diseases

Other diseases not listed above:____

Hospitalizations/Significant injuries:____

____

Surgery/Procedures History: *(check all that apply)*

☐ Appendix
☐ Bladder Suspension
☐ Blood vessel surgery
  ☐ Arteries
  ☐ Veins
☐ Colon/Rectal surgery
☐ Dental surgery
☐ Eye surgery
☐ Gallbladder
☐ Heart Surgery
  ☐ Bypass
  ☐ Heart valve surgery
  ☐ Angioplasty (balloon)
  ☐ Stents
  ☐ Pacemaker
☐ Hysterectomy
  ☐ Complete ☐ Partial
☐ Hernia
☐ Joint replacement/Orthopedic surgery
☐ Kidney surgery
☐ Organ Transplant
☐ Prostate surgery
☐ Thyroidectomy
☐ Sinus surgery
☐ Tonsils and/or adenoids
☐ Tubal Ligation
☐ Vasectomy

Other surgery not listed above:____

☐ Previous reaction to anesthesia: (explain) ____

____

Please list the names of other practitioners you have or are currently seeing:__________________________________

____

Revised 05.2017

Patient Name________________________________

DOB____________________________

Medication List:

Please list **all** prescription and non-prescription medications. This includes vitamins, herbal medicine, supplements, birth control pills, inhalers and over the counter medications.

Medication	Dosage	How often	Disease or Reason	Prescribed by

List all medications you have stopped taking in the last 12 months:____

____

____

Allergies or reactions:

Medication/Food/Environmental	Reaction	Medication/Food/Environmental	Reaction
1.		**2.**	
3.		**4.**	
5.		**6.**	

Preferred Pharmacy:____

Revised 05.2017

Patient Name___________________________________

DOB_____________________________

Name:____

Family History:

Family Member	Age(s)	Living	Cause of Death
Father			
Mother			
Brother(s) #			
Sister(s) #			

Diseases in the family: *(check all that apply)*

☐ Arthritis
☐ Addiction problems
☐ Bleeding problems

☐ Cancer
  ☐ Breast
  ☐ Colon
  ☐ Prostate
  ☐ Other

☐ Depression/Anxiety
☐ Diabetes
☐ Heart disease
☐ High blood pressure

☐ High cholesterol
☐ Kidney disease
☐ Liver disease
☐ Mental Illness

Social History:

Do you live: Alone ☐ with Spouse or Partner ☐ with Family ☐ Other ☐

Who do you rely on for support and help?____

Do you smoke? ☐ Currently ☐ Past ☐ Never _______packs/day for ______years Date quit:_____________________

If you do smoke, are you interested in quitting? ☐ YES ☐ NO

Other nicotine use ☐ YES ☐ NO

Exposure to second hand smoke? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO ☐ Beer ☐ Wine ☐ Liquor How many drinks per week?___________

How many caffeinated beverages per day? ______ ☐ Coffee ☐ Tea ☐ Sodas ☐ Energy Supplements

Any recreational drug use? ☐ YES ☐ NO

Type:____

Do you exercise regularly? ☐ YES ☐ NO If so how many times per week?_____ Type of exercise:________________

Do you feel safe in your home? ☐ YES ☐ NO

How many hours of sleep do you get per night? ____________ Do you wake feeling well rested? ☐ YES ☐ NO

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Patient Name___________________________________

DOB________________________________

Preventative Care:

Date of last Colon and Rectal Screening:__________________

Have you had a bone density (DEXA) exam? ☐ YES ☐ NO Date:________________

Date of last eye exam:_______________ Date of last dental exam:_____________

Immunizations	Date	Immunizations	Date
Tetanus		Hepatitis A	
Influenza/Flu		Hepatitis B	
Pneumonia		Shingles	
Whooping Cough		HPV	

For our FEMALE patients only:

Date of last menstrual period:____________________

Do you have a Gynecologist ☐ YES ☐ NO If yes, Gynecologist name:____________________________________

Date of last PAP test:_______________Date of last mammogram: ______________

Have you gone through menopause? ☐ YES ☐ NO

Menstrual problems: ☐ Irregular ☐ Heavy ☐ Change in frequency____

Number of pregnancies:________ Number of live births: _______Current birth control method:_________________

For our MALE patients only: Date of last PSA test:________________ Date of last rectal exam:________________

For our Pediatric patients only: (Please answer from the child's perspective)

What is the current marital status of the child's parents?
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐ Widower

Who does the child primarily reside with? ☐ Both parents ☐ Mother ☐ Father ☐ Other:__________________

Does the child have siblings? ☐ Yes ☐ No If yes, # of brothers ________ # of sisters ________

Does the child attend daycare? ☐ Yes ☐ No If yes, average # of days per week _______________

If school age, current grade in school________

Kootenai Clinic Neurosurgery

Date_____________________

Patient Name_____________________________________DOB______________________

Sensation Drawing

Mark the area on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Symptom	Ache	Burning	Numbness	Pins & Needles	Stabbing
Symbol	^^^^	XXXX	OOOO	////	====