Patient Name:_____ Date:_____

KootenaiClinic

Appointment Date:_____

Referring Physician:_____ Primary Care Provider:_____

Patient's Last Name:_____ Birthdate:___/___/_____Age_____ ☐ M ☐F

Legal First Name:_____ M.I.____ Social Security #: _____

Mailing Address:_____ Home Phone: (_____) _____-_____

City and State:_____ Mobile Phone: (_____) _____-_____

Zip: _____ Work Phone: (_____) _____-_____

Employer: _____ Email: _____

Spouse / Guardian Last Name:_____ Birthdate:____/____/_____Age_____ ☐M ☐F

Legal First Name:_____ M.I.____ Social Security #: _____

Address if different:_____ Home Phone: (_____) _____-_____

City and State:_____ Mobile Phone: (_____) _____-_____

Zip: _____ Work Phone: (_____) _____-_____

Email: _____

**Race** (please check one)

☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Hispanic/Latino
☐ Asian ☐ White/Caucasian ☐ Black or African American ☐ Multi-racial
☐ Other:_____ ☐ Decline to answer

**Language** (please check one)

☐ English ☐ Spanish ☐ French ☐ German ☐ Chinese
☐ Native North American ☐ American Sign Language ☐ Japanese ☐ Vietnamese
☐ Other:_____

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## Insurance Information

| Primary Insurance | Secondary Insurance |
|---|---|
| Insurance Co. Name: _____ | Insurance Co. Name: _____ |
| Subscriber Name: _____ | Subscriber Name: _____ |
| Insurance Number: _____ | Insurance Number: _____ |
| Group Number: _____ | Group Number: _____ |

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## Industrial Information for <u>Work Injuries</u>

Date of Injury: ____/____/_____State Injured In: _____Employer Name: _____
Industrial Insurance Co.: _____ Claim #: _____ Claim Mgr. Name: _____
Industrial Address: _____Claim Mgr. Phone (___) ___-_____
Industrial Phone: (___) ___-_____ Fax: (___) ___-_____ Claim Mgr. Fax (___) ___-_____

Patient Name:_____ Date:_____

KootenaiClinic

☐New Patient ☐Established Patient Work Injury? ☐No ☐Yes Ht:_____ Wt:_____

**Reason for Visit:**_____

_____

**Onset of Symptoms: _____ Any x-rays, MRI's, etc: _____**

**Medication List (include over the counter and herbals)**

| Name | Dose | Frequency | Reason |
|---|---|---|---|
| | | | |
| | | | |
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**Medication Allergies or Reactions**

| Name | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Medical History

☐Acid reflux
☐Alcohol or Drug Problems
☐Allergy problems
☐Anemia
☐Artery problems
☐Arthritis
☐Asthma
☐Autoimmune disease
☐Bleeding problems
☐Blood clots
☐Cancer
☐Colitis
☐Crohn's disease
☐Depression/Anxiety
☐Diabetes ☐Type I ☐Type II
☐Emphysema/ COPD
☐Other lung problems
☐Esophagitis/Ulcers
☐Gallstones
☐Glaucoma
☐Headaches
☐Heart disease / Attach
☐Heart valve problems
☐High blood pressure
☐High cholesterol
☐Irritable bowel
☐Kidney stones
☐Kidney disease
☐Liver disease/Hepatitis
☐Mental Illness
☐Osteoporosis
☐Recurrent infections
☐Recurrent UTI
☐Seizures
☐Sleep Apnea
☐STD's
☐Stroke
☐Thyroid disease
☐Ulcers
☐Vein problems

Other problems not listed: _____

Explain any of the above if necessary: _____

Hospitalizations: _____

Significant injuries:_____

Patient Name:_____ Date:_____

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**Surgical History and Dates** (Please include dates)

☐Appendix
☐Bladder suspension
☐Blood vessel surgery
☐Arteries
☐Veins
☐Dental surgery
☐Eye surgery
☐Gallbladder
☐Heart surgery
☐Bypass
☐Heart valve surgery
☐Coronary Angioplasty (balloon)
☐Stents
☐Hysterectomy
☐Complete
☐Partial (ovaries removed)
☐Hernia
☐Joint replacement
☐Orthopedic surgery
☐Prostate surgery
☐Tonsils and/or adenoids
☐Tubal ligation
☐Vasectomy

Any previous anesthesia complications (i.e. Malignant Hyperthermia)? If yes, please list:_____
Other surgery not listed above: _____
History of MRSA? ☐No ☐Yes If yes, where?_____

**Family History**

☐Arthritis Family member_____ ☐Addiction problems Family member _____
☐Bleeding problems Family member _____ ☐Cancer Type and Family member _____
☐Depression/Anxiety Family member _____ ☐Diabetes Family member _____
☐Heart disease Family member _____ ☐High blood pressure Family member _____
☐High cholesterol Family member _____ ☐Kidney disease Family member _____
☐Liver disease Family member _____ ☐Mental illness Family member _____
Other Family member _____

**Social History**

Are you ☐Left handed or ☐Right handed?
Married? ☐NO ☐YES Children?☐NO☐YES If yes, number of children_____
Family members living in the home: ☐Mother ☐Father ☐Siblings Others:_____
Do you smoke? ☐Currently ☐Past ☐Never_____packs/day for__years. Other tobacco use?☐NO ☐YES
If you do smoke, would you like information about our smoking cessation program? ☐NO ☐YES
Do you drink alcohol? ☐NO ☐YES☐Beer ☐Wine☐Liquor. How many drinks per week?_____
How many servings of caffeine per day?_____ ☐Coffee ☐Tea ☐Sodas
Any illicit/recreational drug use?☐ NO ☐YES Type _____
Do you have a pain contract? ☐NO ☐Yes If yes, with who? _____
Do you exercise regularly? ☐Yes ☐No If so, how many times per week?_Type of exercise_____
Do you feel safe in your home? ☐NO ☐YES

**Occupation:**_____

Any known occupational exposures? ☐NO ☐Yes If yes please list: _____
Is this a work related injury? ☐NO ☐Yes

**Advance Directive**

Do you have an Advance Directive? ☐NO ☐YES If no, do you want information regarding an Advance Directive? ☐NO ☐YES http://www.sos.idaho.gov/general/hcdr.html
If you do have an Advance Directive set up, please bring in a copy for us to have on file.