Kootenai Clinic: Comprehensive Patient History Form

- Patient Questionnaire and intake

Date:

Name: Date of Birth:

MEDICAL HISTORY: *check all that apply*

☐ Abnormal Cholesterol	☐ Frequent Ankle Swelling	☐ Nose Bleeds
☐ Acne	☐ Gall Bladder Disease	☐ Panic Attacks
☐ Anemia	☐ Goiter	☐ Phlebitis/Blood Clots
☐ Arthritis	☐ Hay Fever/Allergic Rhinitis	☐ Pleurisy
☐ Asthma	☐ Hearing Loss	☐ Pneumonia
☐ Bladder Infection	☐ Heart Failure	☐ Polio
☐ Blood Disorders	☐ Heartburn	☐ Seizure
☐ Bursitis	☐ Hemorrhoids	☐ Sexual Problems
☐ Cancer	☐ Hepatitis	☐ Sexually Transmitted Disease
☐ Colitis	☐ High Blood Pressure	☐ Skin Cancer
☐ Depression	☐ Hypoglycemia	☐ Stroke
☐ Diabetes	☐ Infertility	☐ Thyroid Disease
☐ Difficulty Sleeping	☐ Irregular Heart Beat	☐ Tuberculosis
☐ Emphysema/COPD	☐ Kidney Disease	☐ Ulcers
☐ Excessive Worry/Anxiety	☐ Liver Disease	☐ Visual Problems
☐ Fainting	☐ Nervous Stomach	☐ Other _____

SURGICAL HISTORY: *check all that apply*

☐ Appendectomy	☐ C-section	☐ Hip Replacement
☐ Back Surgery	☐ Eye Surgery	☐ Hysterectomy
☐ Brain Surgery	☐ Facial Surgery	☐ Knee Replacement
☐ Cardiac Bypass	☐ Gallbladder Removal	☐ Tubal Ligation
☐ Cardiac Valve Replacement	☐ Hernia	☐ Other _____

☐ Previous reaction to anesthesia? Please explain: _____

Patient Identification – Write in or attach patient label

Name:

MRN #:

CSN #:

Age/Sex:

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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.

MEDICATIONS	DOSAGE	HOW OFTEN	DISEASE OR REASON	PRESCRIBED BY

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

Are you currently on a pain contract with a provider? ☐ Yes Provider: _____ ☐ No

ALLERGIES OR REACTIONS:

Medication/Food/Environment	Reaction	Medication/Food/Environment	Reaction
1.		4.	
2.		5.	
3.		6.	

PREFERRED PHARMACY: _____

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FAMILY MEDICAL HISTORY:

☐ Adopted ☐ Family History Unknown

Please refer to the key below to identify family members that have the listed illness.

Mom- maternal	**Dad -** paternal
MGM- Maternal Grandmother	**PGM**- Paternal Grandmother
MGF- Maternal Grandfather	**PGF**- Paternal Grandfather

Check all that apply.

FAMILY MEMBER	ILLNESS	FAMILY MEMBER	ILLNESS
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Allergies**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Heart**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Arthritis**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Hypertension**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Asthma**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Kidney Disease**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Back Problems**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Lipids**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Blood Disorders**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Migraines**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Cancer**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Neurological**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**COPD**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Obesity**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Diabetes**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Psychiatric Illness**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Drug/Alcohol**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Respiratory**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Emphysema**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Scoliosis**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Endocrine**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**SIDS**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Genetic**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Stroke**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Gastrointestinal**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**TB**
☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Genitourinary**	☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Thyroid**

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☐ Mom ☐ MGM ☐ MGF ☐ Dad ☐ PGM ☐ PGF ☐ Other	**Other** _____

FAMILY MEDICAL HISTORY- CONTINUED:

FAMILY MEMBER	AGE (S)	LIVING	CAUSE OF DEATH
FATHER		☐ YES ☐ NO	
MOTHER		☐ YES ☐ NO	
BROTHER(S)		☐ YES ☐ NO	
SISTER(S)		☐ YES ☐ NO	

SOCIAL HISTORY:

Do you live: ☐ Alone ☐ with Spouse/Partner ☐ with Family ☐ Other
Who do you rely on for support and help?
Do you smoke? ☐ Currently Packs/day for years ☐ Past Date quite: ☐ Never
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 ☐ Beer ☐ Wine How many drinks per day? ☐ NO
How many caffeinated beverages per day? ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Supplement
Any recreational drugs? ☐ YES Type: ☐ NO
Do you exercise regularly: ☐ YES How many times per week? ☐ NO Type of exercise:
Do you feel safe at home? ☐ YES ☐ NO
How many hours of sleep do you get per night? Do you feel well rested? ☐ YES ☐ NO

PREVENTATIVE CARE:

Date of last colon and rectal screening:
Have you had a bone density (DEXA) exam? ☐ YES Date: ☐ NO

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MEDICAL HEALTH HISTORY:

Date of last eye exam:	Date of last dental exam:

IMMUNIZATION	DATE	IMMUNIZATION	DATE
Tetanus		Hepatitis A	
Influenza/Flu		Hepatitis B	
Pneumonia		Shingles	
Whooping Cough		HPV	

FEMALE patients only
Date of last menstrual period:
Do you have a Gynecologist?: ☐ YES Name: ☐ NO
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:

MALE patients only
Date of last PSA test: Date of last rectal exam:

PEDIATRIC patients only: *Please answer from 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 # of brothers: # of sisters: ☐ NO
Does the child attend daycare? ☐ YES Average # of days per week: ☐ NO
If school age, current grade in school:

Patient/Representative Signature Date

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