Kootenai Clinic New Patient Health History Form

Patient's Legal Name: _____ Patient's Preferred Name: _____ Pronouns: _____

Patient Date of Birth: _____ Today's Date: _____

MEDICAL HISTORY: *check all that apply*

☐ High Cholesterol	☐ Diabetes: Type I or Type II	☐ Seizures
☐ Anemia	☐ Difficulty Sleeping	☐ Sexual Problems: _____
☐ Arthritis: Rheumatoid / Osteoarthritis	☐ Heart Issues: _____	☐ Sexually Transmitted Disease
☐ Asthma / COPD	☐ Heartburn	☐ Sleep Apnea
☐ Blood Disorders / Clotting	☐ Liver Disease	☐ Stroke / TIA
☐ Cancer: _____	☐ High Blood Pressure	☐ Thyroid Disease
☐ Colitis / Celiac / Crohn's	☐ Infertility	☐ Visual / Hearing Problems
☐ Dementia	☐ History of alcohol/drug abuse	☐ Other _____
☐ Depression/ Anxiety/ Panic Attacks	☐ Kidney Disease	

SURGICAL HISTORY: *check all that apply*

☐ Appendectomy	☐ Hysterectomy	☐ Abdominal Surgery: _____
☐ Back Surgery	☐ Facial / Eye/ Sinus Surgery	☐ Cardiac Surgery: _____
☐ Brain Surgery	☐ Tonsillectomy	☐ C- Section: How many? _____
☐ Gall Bladder Surgery	☐ Transplant	☐ Joint Surgery: _____
☐ Hernia Surgery	☐ Tubal Ligation	☐ Other: _____
	☐ Vasectomy	

MEDICATION LIST: *If you have a medication list printed, please provide to clinic staff*

Prescription Medications	Dosage	How Often	Disease or Reason	Prescribed By
Vitamins / Supplements	**Dosage**	**How Often**	**Reason**	

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

Please list other providers you see: _____

_____

PREFERRED PHARMACY: _____

ALLERGIES OR REACTIONS:

Medication / Food / Environment	Reaction	Medication / Food / Environment	Reaction	Medication / Food / Environment	Reaction
1.		2.		3.	

Created: 8/1/2023 Revised:

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SOCIAL HISTORY:

Do you live: ☐ Alone ☐ with Spouse/Partner ☐ with Family ☐ Other Spouse Name: _____
Do you smoke? ☐ Currently Packs/day ___for ____ years ☐ Past; Year quit: ☐ Never
If you do smoke, are you interested in quitting? ☐ YES ☐ NO
Do you vape? ☐ YES ☐ NO Do you chew? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO If yes, how many drinks per week?
Any recreational drugs? ☐ YES ☐ NO If yes, type:
Do you exercise regularly: ☐ YES ☐ NO If yes, how many times per week? 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
Are you currently employed? ☐ YES ☐ NO Occupation if/when employed:

FAMILY MEDICAL HISTORY: ☐ Adopted ☐ Family History Unknown

Illness	Mother	Father	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Sibling	Sibling
Rheumatoid Arthritis								
Asthma / COPD / Emphysema								
Blood Disorder								
Cancer (type? Age diagnosed?)								
Coronary Artery Disease								
Dementia								
Diabetes								
Drug/Alcohol								
Colitis / Crohn's								
Cardiovascular								
High Cholesterol (lipids)								
Hypertension								
Hypothyroid								
Kidney Disease								
Migraines								
Parkinson's								
Psychiatric Illness								
Stroke								

Family Member	Age (s)	Living	Cause of Death
Father		☐ YES ☐ NO	
Mother		☐ YES ☐ NO	
Brother(s)		☐ YES ☐ NO	
Sister(s)		☐ YES ☐ NO	

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PREVENTATIVE CARE AND MEDICAL HEALTH HISTORY:

Date of last colon cancer screening: Type of screening: History of polyps? Y/N Recall interval	
Have you had a bone density (DEXA) exam? ☐ NO ☐ YES Date:	
Date of last eye exam:	Date of last dental exam:

Immunization	Date (s)	Immunization	Date(s)	Immunization	Date(s)
Tetanus / TDaP		Hepatitis A		Pneumonia Prevnar13 Prevnar15 Prevnar20 Pneumovax23	
Influenza/Flu		Hepatitis B			
COVID		HPV		Shingles	

ADOLESCENTS and ADULT patients:
Date of last prostate test (if applicable):
Date of last menstrual period (if applicable):
Date of last PAP test (if applicable): Where Completed: History of abnormal PAP? ☐ YES ☐ NO Date of last mammogram:
Have you gone through menopause (if applicable)? ☐ YES ☐ NO Hysterectomy surgery date:
Menstrual problems (if applicable): ☐ Irregular ☐ Heavy ☐ Change in frequency
If applicable, number of pregnancies: Number of live births: Current birth control method:
PEDIATRIC patients only:
The parents of the child are: ☐ 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:
Does the child have smoke exposure?

Patient / Representative Signature: _____ Date: _____