Primary Care

160 Heritage | Kalispell, MT 59901 | (406) 752-8433

Welcome. In our attempt to provide better and more efficient care for you at your appointment, we encourage you to fill out this form (front and back) prior to your visit with the provider. Thank you for your time and effort.

Date: ________________

Patient Name: ____ Date of Birth: ____________

PAST MEDICAL HISTORY

- ☐ Weight loss / gain
- ☐ Fatigue
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Throat problems
- ☐ Headaches
- ☐ Heart problems
- ☐ High Blood pressure
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Lung problems
- ☐ Ulcers
- ☐ Heartburn
- ☐ Colon problems
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Arthritis / Lupus
- ☐ Liver problems
- ☐ Kidney problems
- ☐ Depression
- ☐ Psychiatric problems
- ☐ Neurological problems
- ☐ Anemia
- ☐ Cancer
- ☐ Sexually transmitted diseases

Describe any of the checked problems:

____

____

ALLERGIES

Drug allergy	Reaction

MEDICATIONS

Name of medication	Dose	When do you take this medication each day?

SURGICAL HISTORY

Please list past surgeries	Dates	Location	Reason

PLEASE TURN OVER

Patient Name: ______________________________ Date of Birth: ____________

FAMILY MEDICAL HISTORY

Please indicate relationship: M - Mother, F - Father, S - Sister, B - Brother, C - Child, MGM - Maternal (mother's side) grandmother, MGF - Maternal Grandfather, PGM - Paternal (father's side) grandmother, PGF - Paternal grandfather

Diabetes ____________ Lung Problems ____________ Stroke ____________

High Blood pressure ____________ Cancer (& type)____________ Thyroid problems ____________

Heart Disease ____________ Colon Problems____________ Mental Health ____________

Other Problems ____

Do you have any siblings? # of Brothers _____ # of Sisters _____

Do you have any children? # of Sons: _______ # of Daughters: _______

SOCIAL HISTORY

Tobacco exposure: Do you smoke?____________ Are you exposed to second hand smoke? ______

If yes, how many packs per day? ____________ Number of years that you have smoked _______

Do you use chewing tobacco? ____________ How many cans per week? ____________

Do you use street drugs? ____________ Number of alcoholic drinks per week: _________

Exercise information: Do you exercise regularly? ____ What type and how often? ____________

Occupation: ____________ **Religion: (optional)** ____________

Who do you live with: ____________ **Marital status:** ____________

IF FEMALE

Age at first period: _________ Date of last period:____________ Date of last Pap Smear: __________

Birth Control Method:

Any abnormal Pap Smears? _________ If so, was the following one normal? ____________

Date of last mammogram: __________ Any breast problems? _______ Age at Menopause: _________

Obstetric History:

Number of Pregnancies:_____ Number of Living children: _____ Number of Miscarriages: _________

Number of Abortions:____________ Number of Premature Deliveries: ____________

Pregnancy Complication: ____

Signature ______________________________ Date: __________

Printed Name ______________________________