Primary Care
705 6th Avenue East | Kalispell, MT 59901 | (406) 755-7366

LOGAN HEALTH

Patient Intake

Name: _____ DOB: _____

Past Medical Problems:

- ☐ Headaches
- ☐ Stroke
- ☐ Seizures
- ☐ Pneumonia
- ☐ Diabetes (type 1 / type 2)
- ☐ Thyroid Disease
- ☐ Glaucoma
- ☐ Eye Glasses (for reading / distance)
- ☐ Macular Degeneration
- ☐ Hearing Loss / Hearing Aids
- ☐ High Blood Pressure
- ☐ Blood Clots
- ☐ Heartburn / Reflux (GERD)
- ☐ Stomach Ulcers
- ☐ Heart Disease
  - ☐ Heart Attack / Bypass
  - ☐ Heart Failure
  - ☐ Angina
  - ☐ Valve Disorder
  - ☐ Pacemaker
- ☐ Atrial Fibrillation
- ☐ High Cholesterol
- ☐ Gastrointestinal Bleeding
- ☐ Hepatitis (A, B, C)
- ☐ HIV / AIDS
- ☐ Chronic Wound
- ☐ Cancer (type) _____
- ☐ Urinary Tract Infections
- ☐ Incontinence (Stool, Urine)
- ☐ Kidney Stones
- ☐ COPD (Emphysema, Chronic Bronchitis)
- ☐ Asthma
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Arthritis (type) _____
- ☐ Gout
- ☐ Osteoporosis
- ☐ Prostate Disease
- ☐ Erectile Dysfunction
- ☐ Pregnancy Complications
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Past Surgeries:

- ☐ Tonsils
- ☐ Appendix
- ☐ Cervical Freezing / LEEP
- ☐ Gallbladder
- ☐ Hernia
- ☐ Hysterectomy with / without ovaries removed
- ☐ Tubal ligation
- ☐ C-section
- ☐ Vasectomy
- ☐ Cataracts
- ☐ _____
- ☐ _____

Hospital Overnight Stays: (list date/reason)

_____

_____

_____

Medications:

☐ Include prescription medicines, vitamins, herbs, supplements, birth control / IUD, and over-the-counter medicines, e.g. pain medicines.

☐ List the name, dosage, and how it's taken (e.g. "daily" or "every 4 hours")

☐ Please bring your medication bottles to the first visit if possible.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies to medicines or food (list allergen and reaction):

_____ _____

_____ _____

Last Colonoscopy: _____ Doctor: _____

Last Bone density test: _____ Location: _____

Last Mammogram: _____ Location: _____

Females only: Number of pregnancies _____ Live births _____ Date of last period _____

Vaccines: (put year of last vaccination):

☐ Please bring a copy of your vaccination records to the visit if possible.

Tetanus _____ Tdap _____ Influenza _____

Prevnar Pneumonia _____ Pneumovax Pneumonia _____

Hepatitis A _____ Hepatitis B _____ TB skin test _____ HPV _____

Zostavax _____ Other _____

Tobacco: ☐ Cigarettes ☐ E-Cigarettes ☐ Smokeless Tobacco ☐ Pipe ☐ Cigars

☐ Current Use: Packs / Cigarettes per day: _____ Age started: _____

☐ Past Use: Age started _____ Age quit _____

Average Packs Per Day During Those Years _____

Alcohol: How many drinks _____ per day / week / month

☐ Please count 1drink as 1shot / 1.5 oz. hard liquor or 5 oz. wine or 12 oz. beer.

Recreational drug use: ☐ Marijuana ☐ Other _____

Do you exercise: Yes / No How Often: _____

Sexually active? Yes / No New partner in the last year? Yes / No

Sexual preference: Men / Women / Both

Do you use a seat belt? Yes / No

Have you been exposed to hazardous materials? Yes / No

Current or Former Occupation: _____

Have you served in the military? Yes / No

Are you on a special diet? Vegetarian / Vegan / Other _____

Do you travel to foreign countries? Yes / No Where? _____

Do you have a religion that would affect your medical care? Yes / No

Family history: (be sure to include psychiatric illnesses, heart problems,cancers, high blood pressure, inherited conditions, and so forth.)

Father:	Alive	Deceased	Illnesses:_____
Mother:	Alive	Deceased	Illnesses: _____
Father's father:	Alive	Deceased	Illnesses: _____
Father's mother:	Alive	Deceased	Illnesses: _____
Mother's father:	Alive	Deceased	Illnesses: _____
Mother's mother:	Alive	Deceased	Illnesses: _____
Sister(s):	Alive	Deceased	Illnesses: _____
Brother(s):	Alive	Deceased	Illnesses: _____
Children:	Alive	Deceased	Illnesses: _____

List your other medical providers (e.g. your Gl doctor, urologist, psychiatrist, counselor, etc.)

_____

_____

_____

Previous Primary care physician (if any): _____