KALISPELL REGIONAL HEALTHCARE

(406) 751-5364

Date of last mammogram ____/____/____ last eye exam _____/_____/_____ last chest x-ray _____/_____/_____

last pap smear _____/_____/_____ last bone densitometry _____/_____/_____ last tuberculosis Test _____/_____/_____

last prostate check _____/_____/_____ last colon cancer screening _____/_____/_____

Stated Height ___________ Stated Weight ___________

As you review the following list, please check any of those problems which have significantly affected you.

GENERAL
- ☐ Recent weight gain amount _______________
- ☐ Recent weight loss amount _______________
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever/Chills
- ☐ Night Sweats

EYES
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

EARS-NOSE-MOUTH-THROAT
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Snoring

HEART
- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs
- ☐ Heart attack

LUNGS
- ☐ Shortness of breath
- ☐ Difficulty in breathing
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing up blood
- ☐ Wheezing (asthma)

MEDICATIONS: ________________________

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____
____
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____

STOMACH / INTESTINES
- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Heartburn
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Change in bowel habits
- ☐ Irritable Bowel Syndrome
- ☐ Ulcer

GENITALS / BLADDER
- ☐ Urinary Incontinence
- ☐ Difficult urination
- ☐ Pain or burning during urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Getting up at night to pass urine
  # of times ___________
- ☐ Discharge from penis / vagina
- ☐ Rash / ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:
- ☐ Vaginal dryness
  Age when periods began: ___________
  Periods regular ☐ Yes ☐ No
  How many days apart? _________
  Date of last period ______________________
  Bleeding after menopause ☐ Yes ☐ No
  Number of pregnancies ______
  Number of miscarriages ______

MUSCLES / JOINTS
- ☐ Morning stiffness
  Lasting how long
  _________ Minutes _________ Hours
- ☐ Joint Pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Broken Bones
- ☐ Joint Swelling
  List joints affected in the last 6 months

____
____
____

BAL THERAPIES / VITAMINS: _______________

____
____
____
____
____
____

SKIN
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules / bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold
- ☐ New moles / changes

HEAD / BRAIN
- ☐ Headaches / Migraines
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss

PSYCHIATRIC
- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily loosing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Frequently do not feel rested

GLANDS
- ☐ Excessive thirst or urination
- ☐ Heat / Cold Intolerance
- ☐ Tremors
- ☐ Palpitations

BLOOD / LYMPH
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion / when _________________

ALLERGY / IMMUNITY
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection
  Do you have allergies? ☐ Yes ☐ No

LIST ALLERGIES (drugs/food/seasonal): ______

____
____
____
____
____
____
____
____
____

PLEASE FILL OUT BOTH SIDES OF THIS FORM

SOCIAL HISTORY

Occupation ___________________________

Do you drink caffeinated beverages? ☐ Yes ☐ No

Cups / glasses per day ___________________________

Do you smoke? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No For how long? ___________

Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week ______

Has anyone ever told you to cut down on your drinking? ☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No

If yes, please list: ___________________________

____

Do you exercise each week? ☐ Yes ☐ No

Type ___________________________

# of days ___________ # of minutes ___________

Hobbies / Activities ___________________________

Who do you live with? ___________________________

Do you have family in the area? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High blood pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness (please list) ___________________________

____

____

____

Natural or Alternative therapies (chiropractic, magnets, massage, etc.) ______

____

____

____

PREVIOUS OPERATIONS

	Type	Year	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			

History of fractures? ☐ Yes ☐ No Describe: ___________________________

History of serious injuries? ☐ Yes ☐ No Describe: ___________________________

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings_________ Number living ________ Number deceased ________

Number of children ________ Number living ________ Number deceased________ List ages of each ___________________________

Health of children: ___________________________

____

Do you know of any blood relative who has or had: (check and give relationship to you)

☐ Asthma ______________	☐ High blood pressure ______________	☐ Tuberculosis ______________
☐ Cancer ______________	☐ Bleeding tendency ______________	☐ Diabetes ______________
☐ Leukemia ______________	☐ Alcoholism ______________	☐ Goiter ______________
☐ Stroke ______________	☐ Rheumatic fever ______________	☐ Other ______________
☐ Colitis ______________	☐ Epilepsy ______________	☐ Other ______________
☐ Heart disease ______________	☐ Psoriasis ______________	☐ Other ______________

DATE UPDATED

____

____

____

____

____

____

Provider Initials __________

Patient's Name ___________________________
(please print)

Age _____ Date __________

PLEASE FILL OUT BOTH SIDES OF THIS FORM