Polson Health
KALISPELL REGIONAL HEALTHCARE
WELLNESS | WALK-IN CARE | SPECIALTY CARE

Welcome to Polson Health. 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.

PATIENT'S NAME: ______________________________

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

Patients Name: ______________________________

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: ______________