Rural Health Clinic

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

Patient Name: ______________________ Birthdate: __/__/________

Mailing Address: ______________________ City/State/Zip: ______________________

Physical Address: ______________________ City/State/Zip: ______________________

Phone Number: Home: ____________ Cell: ____________ Work: ____________

Email Address: ______________________

Gender: M F Marital Status: Single Married Separated Divorced Widowed

Current Tobacco user: Yes No Quit

Patient SSN: ____________ Race: Caucasian Native American African America Other

Allergies to Medications: ______________________

Employer Name: ______________________

Occupation: ______________________

Emergency Contacts (Someone outside of household)

1. Name: ______________________ Relation to Patient: ______________________
   Phone number: ______________________
2. Name: ______________________ Relation to Patient: ______________________
   Phone number: ______________________
3. Name: ______________________ Relation to Patient: ______________________
   Phone number: ______________________

Person responsible for payment

Name: ______________________ Relation to patient: ______________________
Guarantor SSN: ____________ Birthdate: ____________ Gender: M F

Phone number: Home: ______________________ Cell: ______________________

Mailing Address: ______________________ City/State/Zip: ______________________

Physical Address: ______________________ City/State/Zip: ______________________

Employer Name: ______________________ Phone number: ______________________

LOGAN HEALTH
Cut Bank

Patient Name:___________________DOB______________Date________________Sex: M / F Race________________

Please tell us why you are here today____

Please indicate onset date of any conditions you have had:

GENERAL
- _____Serious Infections (e.g. pneumonia)_________
- _____Diabetes Mellitus
- _____Rheumatic Fever
- _____HIV Infection
- ____Cancer (where?)_________

CVS
- _____High Blood Pressure
- _____Congestive Heart Failure
- _____Heart Murmur
- _____Heart Valve Disease
- _____Angina
- _____Heat Attack
- _____High Cholesterol
- _____Abnormal Heart Rhythm
- _____Blood Clots in Veins
- _____Blocked Arteries in Neck
- _____Blocked Arteries in Legs

HEENT
- _____Glaucoma
- _____Allergies "hay fever"
- _____Frequent Ear Infections

RESPIRATORY
- _____Asthma
- _____Emphysema
- _____Blood Clots in Lungs
- _____Sleep Apnea

MUSCULOSKELETAL/EXTREMITIES
- _____Osteoporosis
- _____Rheumatoid Arthritis
- _____Degenerative Joint Disease
- _____Fibromyalgia
- _____Neck Pain (herniated disc)
- _____Back pain (herniated disc)

LYMPHATIC/HEMATOLOGIC
- _____Thyroid Goiter
- _____Over Active Thyroid
- _____Under Active Thyroid
- _____Transfusion
- _____Anemia

GI/GU
- _____Stomach Ulcers
- _____Ulcerative Colitis
- _____Crohns Disease
- _____Bleeding from Intestines
- _____Diverticulitis
- _____Colon Polyps
- _____Irritable Bowel Disease
- _____Hepatitis
- _____Cirrhosis of the Liver
- _____Liver Failure
- _____Pancreatitis
- _____Gallstones
- _____Kidney Stones
- _____Kidney Failure
- _____Prostate Disease
- _____Endometriosis
- _____Sex Transmitted Infection

SKIN/BREAST
- _____Acne
- _____Eczema
- _____Psoriasis
- _____Fibrocystic Breast Disease

NEUROLOGIC/PSYCHIATRIC
- _____Chronic Vertigo
- _____Peripheral Nerve Disease
- _____Migraine Headaches
- _____Stroke
- _____Multiple Sclerosis
- _____Depression
- ____ Anxiety
- _____Alcoholism
- _____Drug Addiction

Comments:

Please indicate the year of any surgeries you have had:

- _____Angioplasty
- _____Carotid Artery Surgery
- _____Other Vascular Surgery
- _____Coronary Bypass Surgery
- _____Chest/Lung Surgery
- _____Tonsillectomy
- _____Neurosurgery
- _____Trauma Related Surgery
- _____Back or Neck Surgery
- _____Hip Surgery
- _____Knee Surgery
- _____Carpal Tunnel Surgery
- _____Sinus Surgery
- _____Ear Surgery
- _____Stomach Surgery
- _____Inguinal Hernia
- _____Colonoscopy
- _____Gallbladder
- _____Appendectomy
- _____Prostate Surgery
- _____Bladder Surgery
- _____Tubal Ligation
- _____C-Section
- _____Hysterectomy
- _____Ovary Removed
- _____Breast Surgery
- _____Thyroid Surgery
- _____Other_________________

Please indicate the year of any preventative tests or services you have had:

- _____Stress Test
- _____Echocardiogram
- _____Chest X-Ray
- _____EKG
- _____Bone Density Test
- _____Flu Vaccine
- _____Pneumonia Vaccine
- _____Tetanus Vaccine
- _____Hepatitis Vaccine
- _____Prevnar
- _____Prostate Cancer Blood Test
- _____Rectal Exam
- _____Colon Cancer Stool Test
- _____Flexible Sigmoidoscopy
- _____Barium Enema
- _____Mammogram/Breast Exam
- _____Pap Smear
- _____Date of Last Physical Exam
- _____Eye Exam
- _____Hearing Exam
- _____Other_________________

*****PLEASE CONTINUE ON OTHER SIDE*****

Please list any allergies or intolerance to any drugs or other substances.____
____
____

Please list current medications, dosages, and how many times per day you take them.

____ ____
____ ____
____ ____
____ ____

FAMILY MEDICAL HISTORY

Please indicate any major illness in you family members. ***M-Mother; F-Father; MGM-maternal grandmother; MGF-maternal grandfather; PGM-maternal grandmother; PMF-paternal grandfather ; S-sibling***

_____Tuberculosis _____Emphysema _____Heart Disease _____High Blood Pressure _____Osteoporosis _____Anxiety/Depression/Mental Illness type Comments:	_____Diabetes Mellitus _____Thyroid Disease _____Amnesia _____Hemophilia ___________________	_____Kidney Disease _____Epilepsy _____Neurological Disorder _____Liver Disease ________________________	_____Breast Cancer _____Ovarian Cancer _____Colon Cancer _____Prostate Cancer ___________________

PERSONAL INFORMATION

Occupation:____

Please write in or circle the information that applies to you:

Marital Status	Living Status	Diet	Exercising	Alternative Medicine
single	alone	none	none	holistic
married	with spouse	low fat	walking	chiropractic
divorced	with parents	low chol	aerobics	homeopathy
widowed	assisted Living	low carb	weightlifting	acupuncture
separated	nursing Home	vegetarian	____days/wk	herbal

Tobacco	Alcohol	Illicit Drugs	Caffeine
never / past/ active	never / past/ active	Never / past/ active	never / past/ active
cigarette / cigar / e-cig	liquor / wine / beer	cocaine / marijuana	coffee / tea / soda
snuff / dip / chewing	_______drinks per	heroin / amphetamine	______cups per day
Start________stop________	day / week / month	barbiturate / LSD / PCP	
packs per day_________	AA / Alcohol Rehab	IV drug Abuse / Drug Rehab	

THANK YOU
FOR TAKING THE TIME TO PARTICIPATE IN YOUR HEALTH CARE!