LOGAN HEALTH

Cut Bank

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: _____

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PEDIATRIC MEDICAL & PERSONAL HISTORY

Patient Name_____DOB_____Date_____Sex: M / F Race_____

Born at_____ Hospital or Other?_____ Birth Weight_____ Inches long_____

Mother's age_____ Total # of Pregnancies_____ Normal labor/deliveries_____ C-Section?_____

Complications_____

-Social Information-

Household	Siblings	Diet	Exercise	Care
Both parents_____	Only child _____	Bottle_____Breast_____	None_____	At home_____
Single parents_____	# of brothers_____	Eats_____ times a day	30 min_____	In home daycare_____
Divorced parents_____	# of sisters_____	_____ ounces a day	1 hr day_____	Public daycare_____
Step parents_____		Takes multivitamins_____	2 hr day_____	

Medications:

Medication	Dose

Allergies:

Allergies	Reaction

Hospitalizations:

Hospitalization/Injury/Fracture	Date

Past Medical History:

Problem	Onset	Problem	Onset	Past Surgical History	
Anemia		GERD		Procedure	Year
Allergic Rhinitis		Hepatitis A B C		Circumcision	_____
Asthma		HIV		Tymp tubes	_____
Blood Transfusion		Irritable bowel		Hernia	_____
Bronchitis		Obesity		Tonsillectomy	_____
Diabetes, NIDDM		Pharyngitis		Adenoidectomy	_____
Diabetes, IDDM		Pneumonia			
Ear Infections		Premature birth			
Epilepsy		Problems in utero			
Febrile Seizure		Urinary tract infection			

Family History: Please indicate M-Mother; F-Father; MGM-maternal grandmother; MGF-maternal grandfather; PGM-maternal grandmother; PMF-paternal grandfather ; S-sibling

Disease	Relative	Disease	Relative	Disease	Relative	Disease	Relative
Anemia		Depression		Hypertension		Renal Failure	
Anxiety		Diabetes		Hyperthyroid		Renal stones	
Allergies		Epilepsy		Hypothyroid		STD	
Asthma		Gout		Irritable Bowel		Sickle Cell	
Blood Clots		Gallstones		Obesity		TB	
Blood Trans.		HA, migraine		Osteoarthritis		Lymphoma	
CAD/MI		HA, tension		Peptic ulcer		Breast CA	
CHF		Hepatitis A B C		Pulmonary Embolus		Ovarian CA	
COPD		HIV		PVD/claudication		Colon CA	
CVD Stroke		Hyperlipidemia		Rheumatoid Arthritis		Prostate CA	