Kootenai Clinic New Patient Health History Form

Patient's Legal Name: _____ **Patient's Preferred Name:** _____ **Pronouns:** _____

Patient Date of Birth: _____ **Today's Date:** _____

MEDICAL HISTORY: *check all that apply*

☐ High Cholesterol	☐ Diabetes: Type I or Type II	☐ Seizures
☐ Anemia	☐ Difficulty Sleeping	☐ Sexual Problems: _____
☐ Arthritis: Rheumatoid / Osteoarthritis	☐ Heart Issues: _____	☐ Sexually Transmitted Disease
☐ Asthma / COPD	☐ Heartburn	☐ Sleep Apnea
☐ Blood Disorders / Clotting	☐ Liver Disease	☐ Stroke / TIA
☐ Cancer: _____	☐ High Blood Pressure	☐ Thyroid Disease
☐ Colitis / Celiac / Crohn's	☐ Infertility	☐ Visual / Hearing Problems
☐ Dementia	☐ History of alcohol/drug abuse	☐ Other _____
☐ Depression/ Anxiety/ Panic Attacks	☐ Kidney Disease	

SURGICAL HISTORY: *check all that apply*

☐ Appendectomy	☐ Hysterectomy	☐ Abdominal Surgery: _____
☐ Back Surgery	☐ Facial / Eye/ Sinus Surgery	☐ Cardiac Surgery: _____
☐ Brain Surgery	☐ Tonsillectomy	☐ C- Section: How many? _____
☐ Gall Bladder Surgery	☐ Transplant	☐ Joint Surgery: _____
☐ Hernia Surgery	☐ Tubal Ligation	☐ Other: _____
	☐ Vasectomy	

MEDICATION LIST: *If you have a medication list printed, please provide to clinic staff*

Prescription Medications	Dosage	How Often	Disease or Reason	Prescribed By
Vitamins / Supplements	**Dosage**	**How Often**	**Reason**	

Are you currently on a pain contract with a provider: ☐ No ☐ Yes which Provider: _____

Please list other providers you see: _____

_____

PREFERRED PHARMACY: _____

ALLERGIES OR REACTIONS:

Medication / Food / Environment	Reaction	Medication / Food / Environment	Reaction	Medication / Food / Environment	Reaction
1.		2.		3.	

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SOCIAL HISTORY:

Do you live: ☐ Alone ☐ with Spouse/Partner ☐ with Family ☐ Other Spouse Name: _____
Do you smoke? ☐ Currently Packs/day ___for ____ years ☐ Past; Year quit: ☐ Never
If you do smoke, are you interested in quitting? ☐ YES ☐ NO
Do you vape? ☐ YES ☐ NO Do you chew? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO If yes, how many drinks per week?
Any recreational drugs? ☐ YES ☐ NO If yes, type:
Do you exercise regularly: ☐ YES ☐ NO If yes, how many times per week? Type of exercise:
Do you feel safe at home? ☐ YES ☐ NO
How many hours of sleep do you get per night? Do you feel well rested? ☐ YES ☐ NO
Are you currently employed? ☐ YES ☐ NO Occupation if/when employed:

FAMILY MEDICAL HISTORY: ☐ Adopted ☐ Family History Unknown

Illness	Mother	Father	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Sibling	Sibling
Rheumatoid Arthritis								
Asthma / COPD / Emphysema								
Blood Disorder								
Cancer (type? Age diagnosed?)								
Coronary Artery Disease								
Dementia								
Diabetes								
Drug/Alcohol								
Colitis / Crohn's								
Cardiovascular								
High Cholesterol (lipids)								
Hypertension								
Hypothyroid								
Kidney Disease								
Migraines								
Parkinson's								
Psychiatric Illness								
Stroke								

Family Member	Age (s)	Living	Cause of Death
Father		☐ YES ☐ NO	
Mother		☐ YES ☐ NO	
Brother(s)		☐ YES ☐ NO	
Sister(s)		☐ YES ☐ NO	

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PREVENTATIVE CARE AND MEDICAL HEALTH HISTORY:

Date of last colon cancer screening: Type of screening: History of polyps? Y/N Recall interval	
Have you had a bone density (DEXA) exam? ☐ NO ☐ YES Date:	
Date of last eye exam:	Date of last dental exam:

Immunization	Date (s)	Immunization	Date(s)	Immunization	Date(s)
Tetanus / TDaP		Hepatitis A		Pneumonia Prevnar13 Prevnar15 Prevnar20 Pneumovax23	
Influenza/Flu		Hepatitis B			
COVID		HPV		Shingles	

ADOLESCENTS and ADULT patients:
Date of last prostate test (if applicable):
Date of last menstrual period (if applicable):
Date of last PAP test (if applicable): Where Completed: History of abnormal PAP? ☐ YES ☐ NO Date of last mammogram:
Have you gone through menopause (if applicable)? ☐ YES ☐ NO Hysterectomy surgery date:
Menstrual problems (if applicable): ☐ Irregular ☐ Heavy ☐ Change in frequency
If applicable, number of pregnancies: Number of live births: Current birth control method:
PEDIATRIC patients only:
The parents of the child are: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐ Widower
Who does the child primarily reside with? ☐ Both parents ☐ Mother ☐ Father ☐ Other:
Does the child have siblings? ☐ YES # of brothers: # of sisters: ☐ NO
Does the child attend daycare? ☐ YES Average # of days per week: ☐ NO
If school age, current grade in school:
Does the child have smoke exposure?

Patient / Representative Signature: _____ Date: _____

Kootenai Clinic Rheumatology: Review of Systems

Patient Name: _____ Date of Birth: _____ Date: _____

Is there anything specific that you would like to discuss at today's visit? If yes, please explain:

Since your last visit to the clinic have you had any of the following occur? Yes or NO and explain:

Problem	Yes	No	Please Explain…
Serious Infection	☐	☐	
Hospitalization	☐	☐	
New Diagnosis	☐	☐	
Surgery	☐	☐	
Changes to Medications	☐	☐	
New Allergies	☐	☐	

Are you experiencing any of the following symptoms? Please check the box below:

General
- ☐ Recent weight gain _____
- ☐ Recent weight loss _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night Sweats
- ☐ Significant Changes in Appetite

EARS, NOSE, MOUTH, THROAT, EYES
- ☐ Nose Bleeds
- ☐ Dryness in nose
- ☐ Sores in Mouth/Nose
- ☐ Dryness in Mouth
- ☐ Excessive Thirst
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Eye Redness
- ☐ Eye Inflammation
- ☐ Loss of Vision
- ☐ Blurred Vision
- ☐ Eye Dryness
- ☐ Feels like something in eye

HEMATOLOGIC
- ☐ Bruises / Bleed Easily
- ☐ Tender/ Swollen Glands

RESPIRATORY
- ☐ Shortness of breath at rest
- ☐ Shortness of breath with activity
- ☐ Difficulty breathing at night
- ☐ Cough

CARDIO
- ☐ Pain in Chest
- ☐ Irregular Heartbeat
- ☐ Sudden changes in heart rate
- ☐ Palpitations
- ☐ Swollen Legs/feet

NEUROLOGIC
- ☐ Numbness and Tingling
- ☐ Headaches
- ☐ Seizures or hallucinations
- ☐ Fainting
- ☐ Muscle Spasm
- ☐ Sensitivity of hands/feet

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Blood in Stools/Black Stool
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Constipation

MUSCULOSKELETAL
- ☐ Morning Stiffness -lasting how long?
  _____
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Weakness
- ☐ Muscle Tenderness

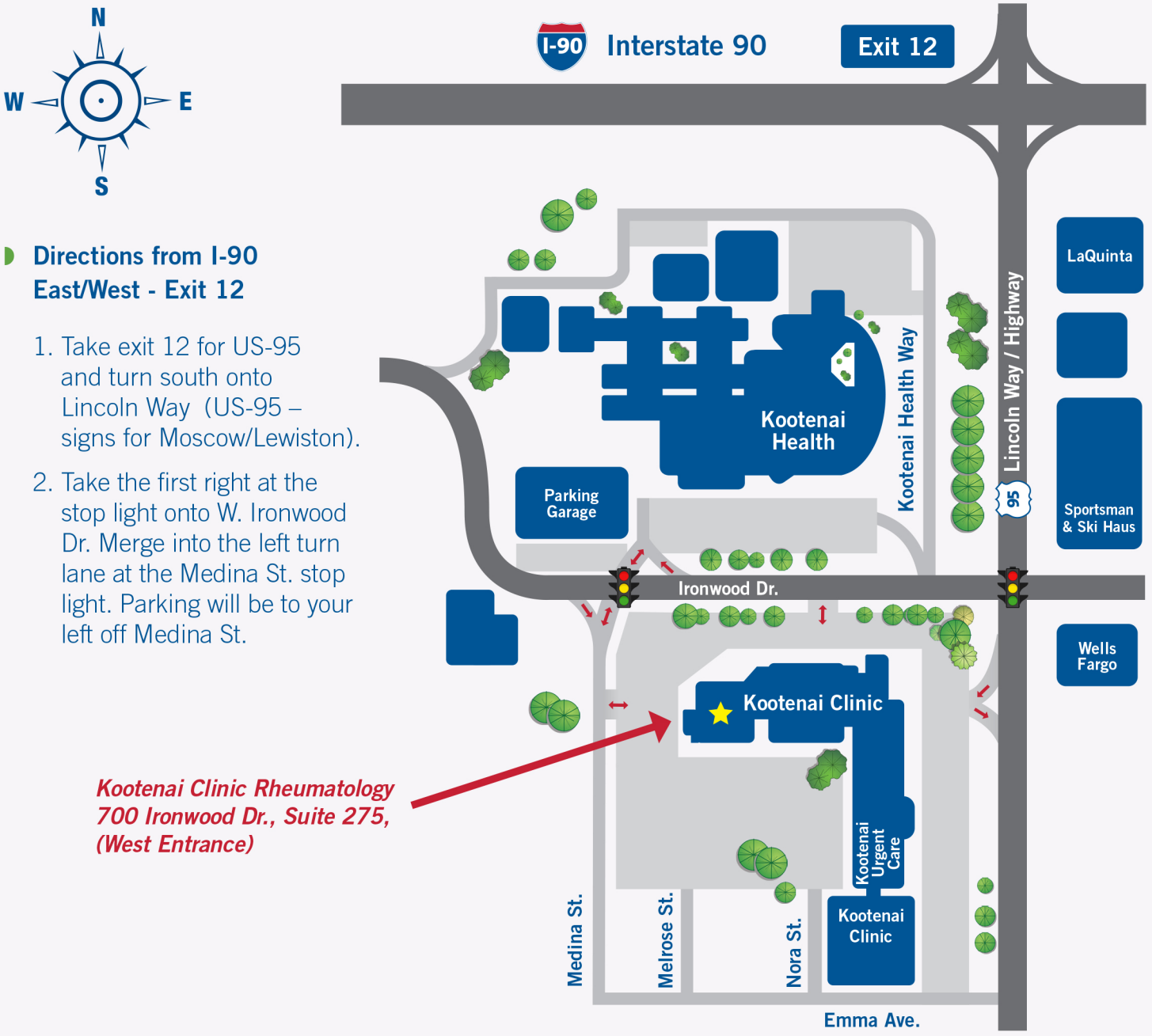
SKIN
- ☐ Redness
- ☐ Rash with Sun Exposure
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Color changes of hands or feet in the cold

Urinary
- ☐ Difficulty Urinating
- ☐ Pain or Burning with Urination
- ☐ Blood in Urine
- ☐ Frequent Urination

BEHAVIORAL
- ☐ Depression
- ☐ Anxiety
- ☐ Difficulty Falling Asleep
- ☐ Difficulty staying Asleep

Patient/Representative Signature: _____ Date: _____

Rheumatology - Coeur d'Alene



Directions from I-90 East/West - Exit 12

1. Take exit 12 for US-95 and turn south onto Lincoln Way (US-95 – signs for Moscow/Lewiston).
2. Take the first right at the stop light onto W. Ironwood Dr. Merge into the left turn lane at the Medina St. stop light. Parking will be to your left off Medina St.

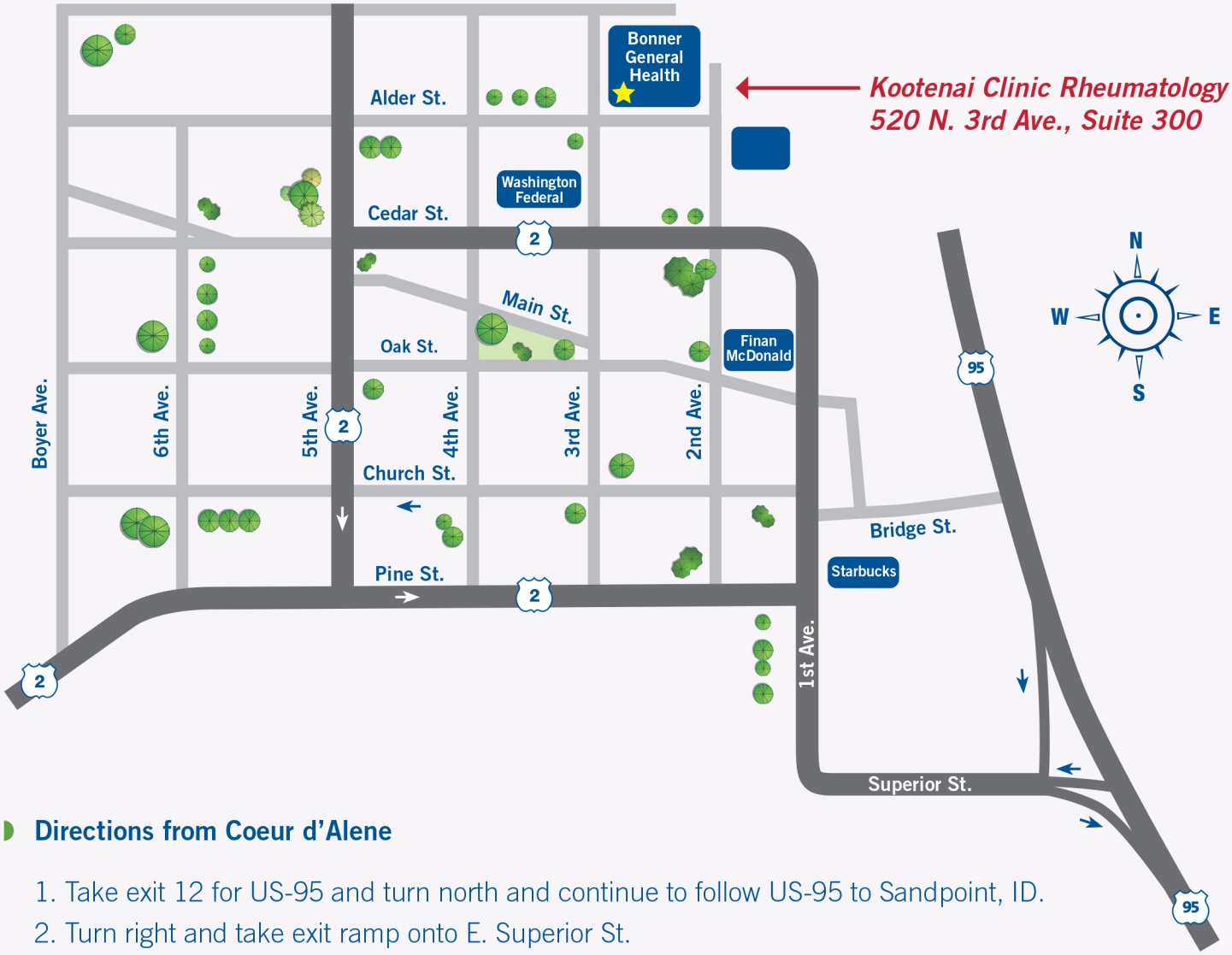
Kootenai Clinic Rheumatology
700 Ironwood Dr., Suite 275,
(West Entrance)

KootenaiClinic

700 Ironwood Drive, Suite 275 | Coeur d'Alene, ID 83814
208.625.4780 **tel** | 208.625.4781 **fax** | kh.org

8.10.2023

Rheumatology - Sandpoint



Directions from Coeur d'Alene

1. Take exit 12 for US-95 and turn north and continue to follow US-95 to Sandpoint, ID.
2. Turn right and take exit ramp onto E. Superior St.
3. Stay straight to go onto 1st Ave.
4. Turn right to stay on 1st Ave.
5. Turn left onto Cedar St. / US-2.
6. Turn right onto 3rd Ave. Cancer Services/Rheumatology is located within Bonner General Health.

KootenaiClinic

520 N. 3rd Avenue, Suite 300 | Sandpoint, Idaho 83864
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4.17.2020