Family Medicine Center
of the Bitterroot, P.C.

ADULT PATIENT HISTORY

Date: _____

Name: _____

Race/Ethnicities (You may decline to answer, however, please note that different races are associated with different health risk factors)_____

_____

Occupation: _____

Marital Status: S M W D

Religion: (Optional) _____

Ages of Children: _____

FOR WOMEN:

No. of pregnancies: _____

No. of deliveries: _____

No. of miscarriages: _____

Type of contraception: _____

Last Pap smear: _____

Last Mammogram: _____

Last Dexa scan: _____

History of abnormal Pap smear: Yes No

ALLERGIES (meds, foods, pollens)

_____

_____

IMMUNIZATION (Date of last.)

Pneumonia: _____

Tetanus: _____

Influenza: _____

Do you have any acute or chronic pain? If so, what pain medications are you taking? _____

CURRENT MEDICATIONS
(Please list all, both prescription and over the counter medications)

_____

_____

_____

_____

MEDICAL PROBLEMS (If none, so state) **YEAR**
(Include all hospitalizations, past and present illnesses)

_____

_____

_____

_____

SURGERIES/PROCEDURES (If none, so state) **YEAR**

_____

_____

_____

_____

FAMILY HISTORY

	Age now	Age at death	Illnesses
Father			
Mother			
Sister(s)			
Brother(s)			
Children			

FAMILY HISTORY - Please write in relatives who have had the following:

Allergies _____
Arthritis _____
Asthma _____
Cancer (type) _____
Diabetes _____
Epilepsy _____
Glaucoma _____
Heart disease _____
High blood pressure _____
High cholesterol or lipids _____
Mental/emotional problems _____
Migraine _____
Stroke _____
Suicide _____
Other inherited diseases _____

HABITS:

Do you smoke cigarettes? Yes No If yes, how much? _____ How long? _____

Have you ever smoked cigarettes? Yes No When did you last quit? _____

Do you use other forms of tobacco? Yes No What kind? _____ How much? _____

How many cups of coffee, tea, or cola do you drink per day? _____

Total number of beers, glasses of wine, or mixed drinks per week? _____

What type of exercise do you get regularly? _____ How often? _____

How often do you use seat belts? 25% 50% 75% 100%

Please Fill Out Reverse Side

MEDICAL PROBLEMS: Give the year you had the problem or a ☐ if you have it now.

_____ ear trouble
_____ eye trouble
_____ frequent colds
_____ frequent headaches
_____ hayfever
_____ sinus trouble
_____ asthma
_____ lung trouble
_____ tuberculosis
_____ blood cholesterol or lipid elevation
_____ heart murmur
_____ heart trouble
_____ high blood pressure
_____ phlebitis
_____ rheumatic fever
_____ varicose veins
_____ vein problem
_____ bowel trouble
_____ diverticulosis/diverticulitis
_____ gallbladder trouble
_____ hemorrhoids
_____ jaundice/hepatitis
_____ liver trouble
_____ pancreas problem
_____ stomach or duodenal ulcer
_____ breast lumps
_____ DES exposure
_____ hernia
_____ kidney or urinary troubles
_____ menstrual problems
_____ prostate trouble
_____ sexually transmitted diseases
_____ arthritis
_____ gout
_____ back trouble
_____ neck trouble
_____ bone fracture or joint injury
_____ anemia
_____ blood disorder
_____ diabetes
_____ thyroid problems
_____ seizures/epilepsy
_____ neurologic disorder
_____ stroke or paralysis
_____ alcoholism
_____ drug abuse
_____ emotional problem
_____ sexual problems
_____ suicide attempt
_____ cancer
_____ congenital condition
_____ skin disease
_____ weight problem
_____ asbestos exposure
_____ radiation therapy
_____ Any other problems:

_____

_____

SYMPTOMS: ☐ if you have any of the following:

_____ ear pain
_____ decreased hearing
_____ persistent hoarseness
_____ blood in sputum
_____ frequent cough
_____ shortness of breath
  _____ on exertion
  _____ lying flat
_____ chest pains
_____ fainting or dizziness
_____ leg pain when walking
_____ swollen ankles
_____ unusual or irregular heartbeat
_____ abdominal pains
_____ bloody or tarry stools
_____ change in appetite
_____ constipation
_____ diarrhea
_____ difficulty swallowing
_____ indigestion
_____ persistent nausea or vomiting
_____ blood in urine
_____ difficulty controlling urine
_____ pain while urinating
_____ urinating at night (more than 2 times)
_____ discharge from penis
_____ difficulty having erection
_____ urethral discharge
_____ vaginal discharge
_____ breast lumps
_____ nipple discharge
_____ hot flashes
_____ pain with intercourse
_____ leg cramps
_____ muscle weakness
_____ painful joints
_____ bruise easily
_____ memory loss
_____ numbness/tingling
_____ tremor
_____ weakness
_____ change in sleep pattern
_____ feelings of despair
_____ usually nervous
_____ fever
_____ night sweats
_____ usually tired

Your reason for requesting an appointment?

_____

_____

_____

_____

NAME _____

Family Medicine Center
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330 N. 10th Street, Ste. A • Hamilton, MT 59840 • Phone: 406-363-DOCS(3627) • Fax: 406-363-3638 • www.familymedcenter.org

Date _____

Dear Mr./Mrs./Ms. _____ Patient Date of Birth _____

The results of your recent labwork are as follows:

Complete Blood Count_____	GOOD/BAD/ANEMIA
Total Cholesterol _____	GOOD/BAD/AVERAGE
LDL ("bad cholesterol") _____	GOOD/BAD/AVERAGE
HDL ("good cholesterol") _____	GOOD/BAD/AVERAGE
Triglycerides _____	GOOD/BAD/AVERAGE
Blood Sugar _____	NORMAL/BORDERLINE/DIABETES
Hemoglobin A1C ____ (goal is below 7.0)	AT GOAL/NEAR GOAL/ABOVE GOAL
Thyroid_____	NORMAL/ABNORMAL
Potassium _____	NORMAL/HIGH/LOW
Pap smear test_____	NORMAL/ABNORMAL
Blood Chemistries _____ (liver, kidneys, protein)	NORMAL/ABNORMAL
Sed rate _____	NORMAL/ABNORMAL
PSA _____	NORMAL/ABNORMAL

The _____ was NORMAL/ABNORMAL

_____ Call for an appointment to discuss the results

_____ Return in _____ week(s) _____ month(s) for a recheck or appointment

_____ Keep up the good work!

Sincerely,

Daniel Child, D.O. • Brenda Kirkland, M.D. • Brett Heath, M.D. • Samantha Kratofil, FNP-C

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PEDIATRIC PATIENT HISTORY

Date: _____

Name: _____

Race/Ethnicities (You may decline to answer, however, please note that different races are associated with different health risk factors)_____

_____

Mother's Name:_____Father's Name _____

Current School and Grade Level_____

Current Sports Played: _____

Religion (optional): _____

Are child's immunizations current: Yes____No____Unsure _

Is your child enrolled in the state immunization registry?

Yes_____No _____

If not, please speak with the nurse for more information.

Previous Physician's Name: _____

Type of Delivery: Vaginal _____C-Section_____

Born at How Many Weeks: _____

Were there any birth complications? _____

_____

Does your child have any learning disabilities or special needs issues? _____

Any mental health issues? _____

ALLERGIES (meds, foods, pollens)

_____

_____

IMMUNIZATION (If applicable)

Pneumonia: _____

Tetanus: _____

Influenza: _____

CURRENT MEDICATIONS

(Please list all, both prescription and over the counter)

_____

_____

_____

_____

MEDICAL PROBLEMS (If none, so state) **YEAR**

(Include all hospitalizations, past and present illnesses)

_____

_____

_____

_____

SURGERIES/PROCEDURES/ BROKEN BONES (If none, so state) **YEAR**

_____

_____

_____

_____

FAMILY HISTORY

	Age now	Age at death	Illnesses
Father			
Mother			
Sister(s)			
Brother(s)			

FAMILY HISTORY - Please write in relatives who have had the following:

Allergies _____
Arthritis _____
Asthma _____
Cancer (type) _____
Diabetes _____
Epilepsy _____
Heart disease _____
High blood pressure _____
High cholesterol or lipids _____
Mental/emotional problems _____
Migraine _____
Suicide _____
Surgeries/Procedures/Broken Bones _____
Other inherited diseases _____
_____
_____

HABITS: (If applicable)

Do you smoke cigarettes? Yes No If yes, how much? _____ How long? _____

Have you ever smoked cigarettes? Yes No When did you last quit? _____

Do you use other forms of tobacco? Yes No What kind? _____ How much? _____

How many cups of coffee, tea, or cola do you drink per day? _____

Do you use alcohol? Yes_____No_____How often do you drink? _____

What type of exercise do you get regularly? _____ How often? _____

How often do you use seat belts? 25% 50% 75% 100%

Please Fill Out Reverse Side

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_____ asthma
_____ lung trouble
_____ tuberculosis
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_____ heart murmur
_____ heart trouble
_____ high blood pressure
_____ phlebitis
_____ rheumatic fever
_____ varicose veins
_____ vein problem
_____ bowel trouble
_____ diverticulosis/diverticulitis
_____ gallbladder trouble
_____ hemorrhoids
_____ jaundice/hepatitis
_____ liver trouble
_____ pancreas problem
_____ stomach or duodenal ulcer
_____ breast lumps
_____ DES exposure
_____ hernia
_____ kidney or urinary troubles
_____ menstrual problems
_____ prostate trouble
_____ sexually transmitted diseases
_____ arthritis
_____ gout
_____ back trouble
_____ neck trouble
_____ bone fracture or joint injury
_____ anemia
_____ blood disorder
_____ diabetes
_____ thyroid problems
_____ seizures/epilepsy
_____ neurologic disorder
_____ stroke or paralysis
_____ alcoholism
_____ drug abuse
_____ emotional problem
_____ sexual problems
_____ suicide attempt
_____ cancer
_____ congenital condition
_____ skin disease
_____ weight problem
_____ asbestos exposure
_____ radiation therapy
_____ Any other problems:

_____
_____

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_____ frequent cough
_____ shortness of breath
_____ on exertion
_____ lying flat
_____ chest pains
_____ fainting or dizziness
_____ leg pain when walking
_____ swollen ankles
_____ unusual or irregular heartbeat
_____ abdominal pains
_____ bloody or tarry stools
_____ change in appetite
_____ constipation
_____ diarrhea
_____ difficulty swallowing
_____ indigestion
_____ persistent nausea or vomiting
_____ blood in urine
_____ difficulty controlling urine
_____ pain while urinating
_____ urinating at night (more than 2 times)
_____ discharge from penis
_____ difficulty having erection
_____ urethral discharge
_____ vaginal discharge
_____ breast lumps
_____ nipple discharge
_____ hot flashes
_____ pain with intercourse
_____ leg cramps
_____ muscle weakness
_____ painful joints
_____ bruise easily
_____ memory loss
_____ numbness/tingling
_____ tremor
_____ weakness
_____ change in sleep pattern
_____ feelings of despair
_____ usually nervous
_____ fever
_____ night sweats
_____ usually tired

Your reason for requesting an appointment?

_____
_____
_____
_____

NAME _____

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NEWBORN/INFANT INITIAL PATIENT HISTORY

Date:_____ Date of Birth_____

Baby's Name_____

Birth weight _____ Discharge weight_____

Mother's Name_____

Father's Name_____

Phone Number:_____

How many brothers/ sisters_____

Did the baby get its first Hepatitis B immunization in the hospital?_____

Was the baby full term?_____ If early, at how many weeks? _____

Any problems with delivery? _____

_____

Did baby pass hearing screen done in hospital?_____

Any previous surgeries/ procedures or known medical problems?_____

Does anyone in the household smoke?_____

Is the baby breastfeeding or bottle feeding? _____

If taking formula,which brand, how much and how often? _____

FAMILY HISTORY - Please write in relatives who have had the following: (Mother, Father, Paternal Grandparents, Maternal Grandparents, Paternal Uncle, brother)

Allergies _____ Cystic Fibrosis _____

Arthritis_____ Mental/emotional problems_____

Asthma_____ Hemophilia_____

Cancer (type) _____ Autism_____

Diabetes _____ Downs Syndrome_____

Epilepsy _____ Congenital Heart disease_____

High blood pressure_____ Other inherited diseases_____

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PATIENT REGISTRATION / FINANCIAL AGREEMENT

Thank you for taking time to complete this form. This information is necessary for the preparation of your clinic records. You are responsible for all charges as billed. PLEASE INFORM RECEPTIONIST IF VISIT IS WORKER'S COMP OR AUTO ACCIDENT RELATED.

PLEASE PRINT AND COMPLETE THE ENTIRE FORM.
WE ARE UNABLE TO BILL INSURANCE WITHOUT BIRTH DATES AND SS#.

PATIENT INFORMATION

Patient Name:

_____
First Middle Last

Gender M / F Birthdate _____

SS# _____

Mailing address _____

City _____State _____ Zip _____

Phone: home: _____ cell:_____

Email:_____ Portal: ❑ Yes ❑ No

EMPLOYER INFORMATION

Employer Name _____

Employer address _____

City _____State _____ Zip _____

Employer Phone: _____

Occupation:_____

Which pharmacy do you typically use? _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone: _____ Alt. Phone:_____

Address: _____

_____

IF PATIENT IS A MINOR

Mother's Name: _____

Phone _____

Mailing address _____

City _____State _____ Zip _____

Birthdate _____ SS# _____

Mother's Employer: _____

Employer's Phone Number: _____

Father's Name: _____

Phone _____

Mailing address _____

City _____State _____ Zip _____

Birthdate _____ SS# _____

Father's Employer: _____

Employer's Phone Number: _____

IF PATIENT IS AN ADULT

_____Married _____Single _____Divorced _____Widowed

If married:
Spouse's Name _____

Phone_____

Birthdate _____ SS# _____

Spouse's Employer: _____

Employer's Phone Number: _____

INSURANCE

If you have **NO** insurance, check here:_____

Name of Insurance Company _____

Policy Holder's Name: _____
First Middle Last

Policy Holder's ID # _____ Group Number_____

Name of Secondary Insurance Company _____

Policy Holder's Name: _____

Policy Holder's ID # _____ Group Number_____

***** Please provide copies of your insurance cards to the receptionist to insure accurate billing.**

I authorize the release of any medical information which may be requested to process claims for payment of medical services through my insurance carrier, prepaid medical plan, or government agency. I authorize payments to be made to the clinic or it's physicians. I assume liability for all non-covered charges and deductibles. By providing a mobile/ cell number I have authorized contact through that number for any activity involving services to me, including but not limited to the resolution of balances on my account. This number will not be shared with any party other than those in-house or any business entity contracted to perform duties resulting from services provided to me by this office. By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices of Family Medicine Center of the Bitterroot.

_____
Signature of Responsible Person Date Relationship

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PATIENT AUTHORIZATION FORM

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of test, procedures and financial information. Under the requirements of H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures regarding your prior consent.

I authorize Family Medicine Center of the Bitterroot to release my records and any information requested to the following individuals.

1. _____ **Relation to Patient** _____
2. _____ **Relation to Patient** _____
3. _____ **Relation to Patient** _____
4. _____ **Relation to Patient** _____

Authorization Regarding Messages

(please check all that apply)

_____ **I authorize you to leave a detailed message on my home or cell number regarding appointments**

_____ **I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.**

_____ **I authorize you to leave a message with anyone who answers the phone.**

_____ **Messages may only be left with** _____

Patient Name (Please print) (Date)

_____

Patient signature

_____