WELCOME!

Thank you for trusting us with your health care. We will try to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us. **208.359.2263**

Patient Information

Date_____ Sex____[M] ____[F] Age_____ Birthdate_____

Patient Name [last]_____[first]_____[MI]_____

Address_____

City_____ State_____ Zip_____

[ ] Married [ ] Widowed [ ] Single [ ] Minor [ ] Separated [ ] Divorced [ ] Partnered for____years

Occupation_____ Patient Employer/School_____

Employer/School Phone (_____)_____ Spouse: Name_____

Spouse: Birthdate_____Spouses: Phone (_____)_____

Spouse: Cell (_____)_____Referred by?_____

Phone Numbers

Home (____)_____ Cell (____)_____

Best time/place to reach you_____

IN CASE OF AN EMERGENCY, CONTACT:

Name_____ Relationship _____

Home (____)_____ Work (____)_____

Date of last physical_____

What is your reason for this visit?_____

Family History

[Father]	[Mother]	[Spouse]
[ ] Alive [ ] Deceased	[ ] Alive [ ] Deceased	[ ] Alive [ ] Deceased
Present health/cause of death:	Present health/cause of death:	Present health/cause of death:
_____	_____	_____
_____	_____	_____

Check illnesses which have occurred in any of your **blood relatives**

[ ] Diabetes [ ] Heart Disease [ ] Cancer [ ] Stroke [ ] Nervous illness
[ ] Bleeding tendency [ ] High Blood Pressure [ ] Kidney Disease
[ ] Allergy [ ]Tuberculosis [ ] Other_____

Patient Health History

Mark all symptoms you have or have had in the past year

GENERAL
[ ] Chills
[ ] Dizziness/Fainting
[ ] Fever
[ ] Forgetfulness
[ ] Headache
[ ] Loss of sleep
[ ] Loss of weight
[ ] Numbness
[ ] Sweats

SKIN
[ ] Bruise easily
[ ] Hives
[ ] Itching/rash
[ ] Change in moles
[ ] Scars
[ ] Unhealing sore

GENITO-URINARY
[ ] Blood in urine
[ ] Frequent urination
[ ] Lack of bladder control
[ ] Painful urination

EYE,EAR,NOSE,THROAT
[ ] Bleeding gums
[ ] Blurred vision
[ ] Crossed eyes
[ ] Difficulty swallowing
[ ] Double vision
[ ] Earache/Ear discharge
[ ] Hayfever
[ ] Hoarseness
[ ] Loss of hearing
[ ] Nosebleeds
[ ] Persistent cough
[ ] Ringing in ears
[ ] Sinus Problems
[ ] Vision-Flashes/Halos

CARDIOVASCULAR
[ ] Chest pain
[ ] High/Low blood pressure
[ ] Irregular/Rapid heartbeat
[ ] Poor circulation
[ ] Swelling of ankles
[ ] Varicose veins

GASTROINTESTINAL
[ ] Poor appetite
[ ] Bloating
[ ] Bowel changes
[ ] Constipation
[ ] Diarrhea
[ ] Excessive thirst
[ ] Gas
[ ] Hemorrhoids
[ ] Indigestion
[ ] Nausea
[ ] Rectal bleeding
[ ] Stomach pain
[ ] Vomiting
[ ] Vomiting blood

MEN ONLY
[ ] Erection difficulties
[ ] Lump on testicles
[ ] Penis discharge
[ ] Sore on penis
[ ] Other

MUSCLE/JOINT/BONE
[ ] Arms [ ] Hips
[ ] Back [ ] Legs
[ ] Feet [ ] Neck
[ ] Hands [ ] Shoulders

WOMEN ONLY
[ ] Abnormal pap smear
[ ] Bleeding between periods
[ ] Breast lump
[ ] Extreme menstruation pain
[ ] Hot flashes
[ ] Nipple discharge
[ ] Painful Intercourse
[ ] Vaginal discharge
[ ] Other
Date of last:
menstrual period_____
Pap smear_____
Have you had a mammogram? _____
Are you pregnant? _____
Number of children_____

Mark all conditions you have or have had in the past

[ ] AIDS
[ ] Appendicitis
[ ] Arthritis
[ ] Asthma
[ ] Bleeding disorders
[ ] Breast lump
[ ] Cancer
[ ] Cataracts
[ ] Chemical dependency
[ ] Chicken pox
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Glaucoma
[ ] Heart disease
[ ] Hepatitis
[ ] Herpes
[ ] High cholesterol
[ ] HIV positive
[ ] Kidney disease
[ ] Liver disease
[ ] Measles
[ ] Migraine headaches
[ ] Multiple sclerosis
[ ] Mumps
[ ] Pacemaker
[ ] Pneumonia
[ ] Polio
[ ] Prostate problems
[ ] Rheumatic fever
[ ] Scarlet fever
[ ] Stroke

List medications you are currently taking_____

_____

Pharmacy name_____Phone (____)_____

Allergies to medications or substances_____

Mark which you use and how much: [ ] Caffeine_____ [ ] Street drugs_____ [ ] Tobacco_____ [ ] Other_____
_____

Mark if your work exposes you to: [ ] Stress [ ] Heavy lifting [ ] Hazardous substances [ ] Other_____
_____

Signatures

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Brett Bagley,P.A. if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient/Parent/Guardian/Personal Representative Date

_____ _____
Print name of Patient/Parent/Guardian/Personal Representative Relationship