

Pend Oreille Health Care
NEW PATIENT INFORMATION FORM

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Please print clearly:

Name _____ Date _____

Address _____ Apt. # _____

City _____ State _____ ZIP _____

Shipping Address _____

Home Phone () _____ - _____ Work Phone () _____ - _____

e-mail address _____

REFERRED BY: _____

Occupation: _____ Employer: _____

Date of Birth _____ Age _____ Sex: M/F Height _____ Weight _____

Overall Health: (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief Complaint (reason you are here): (use separate sheet if more room is needed) _____

Previous treatments for this complaint: _____

Other complaints or problems: (use separate sheet if needed) _____

Current medications/drugs being taken: (use separate sheet if needed) _____

Are you currently under the care of a physician or other health care professionals? (If yes, please give name and date of last visit): _____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (If yes, indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

Office use only:

Pend Oreille Health Care

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Name: _____ Date: _____

HISTORY:

List any major illnesses (with approximate dates): _____

List any surgery or operations (with approximate dates): _____

Past accidents or injuries: _____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other (if other, please explain) _____

Any household pets or other animals you or family members are in close contact with: _____

What can we do to make you happier? _____

SIGNED: _____ DATE: _____