Idaho Falls Clinic, PA
2001 South Woodruff, Suite 15
Idaho Falls, ID 83404
(208) 522-7310

Patient Identification

Date _____

Name _____ Birth Date _____ Age _____

Address _____ City _____ State _____ Zip _____

Phone Number – Home: _____ Work: _____

Referring Physician _____

Insurance and/or Medicare # _____ Social Security # _____

Medicaid Number _____

Who is Financially Responsible for your Medical Care? _____

Problems: (State reasons you want to see a doctor. List in order of importance to you.) You may use back of page to describe in detail if you wish.

1. _____
2. _____
3. _____
4. _____

List other physicians seen in the last two years and why

_____

_____

_____

Past Medical History

*Childhood Diseases

a) _____
b) _____
c) _____

*Adult Illnesses (do not list operations here)

a) _____
b) _____
c) _____
d) _____
e) _____

*Surgery (dates, operation and hospital)

a) _____
b) _____
c) _____
d) _____
e) _____

*Injuries, Accidents

a) _____
b) _____
c) _____

*Drug Allergies (describe reactions if present, List other drugs not mentioned)

Penicillin _____
Sulfa Drugs _____
Other Antibiotics _____
_____
_____
_____

Aspirin _____
Codeine _____
Demerol _____
Anesthetics _____
Other Drugs _____
_____

Current Medications:

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____