Idaho Stork

Glen S. Lovelace, M.D., Jennifer L. Hudson, D.O.
Angela M. Latta, NP-C Kristi Rhodes, CNM Mega Kitterman, CNM

333 N. 1st Street Suite 260 Boise, ID 83702
Phone: 208-345-3136 Fax: 345-0984 www.idahostork.com

Chart Number: _____

Patient Name(legal name): _____ Nickname: _____

Birthday: _____ Age: _____ SS#: _____

Mailing Address: _____

City: _____ State, Zip: _____ Marital Status: - select -

Daytime Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Appointment Reminder: - select -

Employer: _____ Occupation: _____

Spouse/Partner Name: _____ Birthday: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Primary Insurance: _____ Policy Holder: - select -

Group #: _____ Policy / ID #: _____

***** If the patient is a **minor** OR **under a parents insurance** the following information is **REQUIRED** *****

Policy Holder's Name: _____ Employer: _____ Date of Birth: _____

Policy Holder's Address: _____

Secondary Insurance: _____ Policy Holder: - select -

Group #: _____ Policy / ID #: _____

***** If the patient is a **minor** OR **under a parents insurance** the following information is **REQUIRED** *****

Policy Holder's Name: _____ Employer: _____ Date of Birth: _____

Policy Holder's Address: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referred to our clinic by: _____ Primary Care Physician: _____

Preferred Hospital (for insurance): _____ Preferred Pharmacy: _____

Your insurance company expects us to collect your co-payment at the time of service. All accounts are due and payable at time of visit unless other arrangements are made prior to your appointment. I hereby authorize the Physicians to release any information acquired in the course of my treatment to my insurance company if requested. Additionally, I authorize payment to be made to "Glen Lovelace MD PA" for any and all medical or surgical services rendered. I also give my consent to view my prescription history. *I understand I am financially responsible for charges not paid by my insurance company*. I also understand I will receive charges outside Idaho Stork for lab work, pathology, x-rays, and other medical procedures that may or may not be covered by my insurance company.

Signature: _____ **Date:** _____

NAME: _____ DOB: _____ DATE: _____

Family History	Living Age	Living Health	Deceased Age	Deceased Cause
Father				
Mother				
Brother or sister 1				
2				
3				
4				
5				
Husband				
Son or daughter 1				
2				
3				
4				
5				

Has any relative ever had	NO	YES	Who
Cancer	☐	☐	
Tuberculosis	☐	☐	
Diabetes	☐	☐	
Heart trouble	☐	☐	
High blood pressure	☐	☐	
Stroke	☐	☐	
Epilepsy	☐	☐	
Suicide	☐	☐	
Mental illness	☐	☐	
Hysterectomy	☐	☐	
Cesarean section	☐	☐	
Kidney disease	☐	☐	

Menstrual History

Age at onset _____

Regular ☐ Yes ☐ No

Cycle _____ days (from start to start)

Usual duration _____ days

Flow ☐ Light ☐ Mod ☐ Heavy

Pains or cramps ☐ Yes ☐ No

Date of last period _____

List Pregnancies (include miscarriages)

Year	Weight	Sex	Hours of labor	Anesthesia	Complications

Personal History

Weight Now _____ 1 year ago _____ Highest _____ When _____

Method of Contraception _____ Date Last Pap Smear _____

Have you ever had	NO	YES
German measles	☐	☐
Mumps	☐	☐
Chicken pox	☐	☐
Scarlet fever	☐	☐
Diptheria	☐	☐
Pneumonia	☐	☐
Rheumatic fever	☐	☐
Heart disease	☐	☐
Heart murmur	☐	☐
Polio or meningitis	☐	☐
Kidney infections	☐	☐
Gonorrhea or syphilis	☐	☐
Anemia	☐	☐
Jaundice	☐	☐
Gallbladder disease	☐	☐
Epilepsy	☐	☐
Migraine headaches	☐	☐
Tuberculosis	☐	☐
Mononucleosis	☐	☐
Cancer	☐	☐
High or low blood pressure	☐	☐
Nervous breakdown	☐	☐
Breast disease	☐	☐
Thrombophlebitis or blood clots	☐	☐
Fractures or injuries	☐	☐
Liver Disease or Hepatitis	☐	☐
Diabetes	☐	☐

Do you now have or have you ever had	NO	YES
Abnormal Pap Smear	☐	☐
Any eye disease, injury, impaired sight	☐	☐
Any ear disease, injury, impaired hearing	☐	☐
Any trouble with nose, sinuses, mouth, throat	☐	☐
Any head injury, fainting spells, convulsions	☐	☐
Frequent or severe headaches	☐	☐
Skin disease	☐	☐
Chronic or frequent cough	☐	☐
Chest pain, or spitting up of blood	☐	☐
Night sweats	☐	☐
Shortness of breath	☐	☐
Swelling of hands, feet, or ankles	☐	☐
Varicose veins	☐	☐
Kidney or bladder disease	☐	☐
Indigestion, stomach trouble or ulcer	☐	☐
Rectal bleeding, constipation or diarrhea	☐	☐
Loss of urine with cough or sneeze	☐	☐
Do you have any sexual problems	☐	☐
If yes, do you wish to discuss them	☐	☐
Asthma	☐	☐

Alcoholic Beverages ☐ Never ☐ Moderate ☐ Daily

Cigarettes _____ packs per day

Surgery -- what, when, where

_____

_____

Allergies - NO ☐ YES ☐ TO WHAT(?) _____

Transfusions - NO ☐ YES ☐ Number _____

What medicine are you now on: _____