

Kootenai Clinic New Patient Health History Form

Patient's Legal Name: _____ Patient's Preferred Name: _____ Pronouns: _____

Patient Date of Birth: _____ Today's Date: _____

MEDICAL HISTORY: *check all that apply*

High Cholesterol

Anemia •

Arthritis: Rheumatoid / Osteoarthritis / -0.002 Tw 1.33 Td 0577 TT1y 9 MCID BDC /C1T s5.3 (h(A)-8-0.7e3.4i)-3.2 (a)TJ0 Tc 0 T

