



Oregon Medical Group

New Patient

Medical History Form

Date _____

Patient Name _____

Date of Birth _____ Age _____

Other Physicians involved in my care _____

What areas or issues would you like to discuss today? (Please limit to two items)

Present Medications*: (Include birth control pills and non-prescriptive items such as vitamins, aspirin, herbs, etc.)

Name:	Dose:	Times/Day:	Name:	Dose:	Times/Day:
1. _____	_____	_____	5. _____	_____	_____
2. _____	_____	_____	6. _____	_____	_____
3. _____	_____	_____	7. _____	_____	_____
4. _____	_____	_____	8. _____	_____	_____

* Please bring your medication bottles to your office visit

Drug Allergies:

Medication:	Type of Reaction:	Medication:	Type of Reaction:
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

PERSONAL MEDICAL HISTORY Have you been diagnosed with any of the following conditions? NONE LISTED

<p>HEART/VASCULAR DISEASE:</p> <p><input type="checkbox"/> Coronary Artery Disease</p> <p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Abdominal Aortic Aneurysm</p> <p><input type="checkbox"/> Congestive Heart Failure</p> <p><input type="checkbox"/> Aortic Valve Disorder</p> <p><input type="checkbox"/> Atrial fibrillation</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Hyperlipidemia</p> <p><input type="checkbox"/> Deep Vein Thrombosis (DVT)</p> <p><input type="checkbox"/> Peripheral Vascular Disease</p> <p><input type="checkbox"/> Heart Valve – Artificial</p> <p><input type="checkbox"/> Heart Valve – Disorder</p> <p><input type="checkbox"/> Other _____</p> <p>INFECTIOUS DISEASE:</p> <p><input type="checkbox"/> Other _____</p> <p>MUSCULOSKELETAL:</p> <p><input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Osteoarthritis</p> <p><input type="checkbox"/> Fibromyalgia</p>	<p><input type="checkbox"/> Osteopenia</p> <p><input type="checkbox"/> Osteoporosis</p> <p>RESPIRATORY:</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Chronic Obstructive Pulmonary Disease</p> <p><input type="checkbox"/> Sleep Apnea</p> <p><input type="checkbox"/> Other _____</p> <p>GASTROINTESTINAL:</p> <p><input type="checkbox"/> Gastric Ulcers</p> <p><input type="checkbox"/> Hepatitis, Type _____</p> <p><input type="checkbox"/> GERD</p> <p><input type="checkbox"/> Other _____</p> <p>KIDNEY/BLADDER:</p> <p>Benign Prostate Hypertrophy</p> <p><input type="checkbox"/> Erectile Dysfunction</p> <p><input type="checkbox"/> Chronic Kidney Disease</p> <p><input type="checkbox"/> Hypogonadism</p> <p><input type="checkbox"/> Incontinence – Urinary</p>	<p><input type="checkbox"/> Kidney Stones</p> <p><input type="checkbox"/> Overactive Bladder</p> <p><input type="checkbox"/> PSA – Elevated</p> <p><input type="checkbox"/> Other _____</p> <p>GYNECOLOGICAL:</p> <p><input type="checkbox"/> Pap – Abnormal</p> <p><input type="checkbox"/> Other _____</p> <p>MENTAL HEALTH/NEUROLOGIC:</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Cerebral Vascular Accident (CVA)</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Drug Abuse</p> <p><input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/> Migraine</p> <p><input type="checkbox"/> Neuropathy</p> <p><input type="checkbox"/> Parkinson's Disease</p> <p><input type="checkbox"/> Attention Deficit Disorder (ADD)</p> <p><input type="checkbox"/> Other _____</p>	<p>METABOLIC/NUTRITION:</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Hyperthyroidism</p> <p><input type="checkbox"/> Hypothyroidism</p> <p><input type="checkbox"/> Impaired Fasting Glucose</p> <p><input type="checkbox"/> Obesity</p> <p><input type="checkbox"/> Vitamin B12 Deficiency</p> <p><input type="checkbox"/> Vitamin D Deficiency</p> <p><input type="checkbox"/> Other _____</p> <p>CANCER:</p> <p><input type="checkbox"/> Breast Cancer</p> <p><input type="checkbox"/> Lung Cancer</p> <p><input type="checkbox"/> Cancer – Melanoma</p> <p><input type="checkbox"/> Colon Cancer</p> <p><input type="checkbox"/> Skin Cancer</p> <p><input type="checkbox"/> Prostate Cancer</p> <p><input type="checkbox"/> Other Cancer: _____</p>
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PLEASE CONTINUE TO NEXT PAGE



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Today's Date _____

Patient Name _____

Date of Birth _____

SURGICAL HISTORY Have you ever had any of the following operations? (Please list year that specified surgery was performed)

	Year of Surgery		Year of Surgery		Year of Surgery
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Amputation	_____	<input type="checkbox"/> Craniotomy	_____
<input type="checkbox"/> Gall Bladder Removal	_____	<input type="checkbox"/> Colon Resection	_____	<input type="checkbox"/> Gastric Bypass	_____
<input type="checkbox"/> Heart Surgery (specify)	_____	<input type="checkbox"/> Nephrectomy	_____	<input type="checkbox"/> Knee Arthroscopy	_____
<input type="checkbox"/> Back/Neck Surgery	_____	<input type="checkbox"/> Prostatectomy	_____	<input type="checkbox"/> Carotid Endarterectomy	_____
<input type="checkbox"/> Knee/Hip Replacement	_____	<input type="checkbox"/> Pacemaker	_____	<input type="checkbox"/> Shoulder Surgery	_____
<input type="checkbox"/> Thyroidectomy	_____	<input type="checkbox"/> Cataract	_____	<input type="checkbox"/> Tonsillectomy	_____
<input type="checkbox"/> Hemorrhoidectomy	_____	<input type="checkbox"/> Carpal Tunnel	_____	<input type="checkbox"/> Vertebroplasty	_____
<input type="checkbox"/> Transurethral Resection of the Prostate (TURP) _____					

Other Hospitalizations, operations, serious illnesses or injuries: (omit pregnancies)

	Date: _____		Date: _____
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

SOCIAL HISTORY

Occupation: _____

Marital Status: Single Married Domestic Partnership Divorced Widowed

Do you have children? Yes No

Religion affect care? Yes No

Who lives at home with you? _____

Do you drink alcohol? Yes No How many per day? _____ Quit/When: _____

Do you use caffeine? Yes No How many per day? _____

Do you exercise? Yes No

Do you smoke tobacco? Never Former – Quit _____ Current smoker, how much? _____

Chew tobacco? Never Former – Quit _____ Current, how much? _____

Cigar or Pipe use? Never Former – Quit _____ Current smoker, how much? _____

Passive Smoke Exposure? Yes No

Do you use a seat belt? Yes No

Have you used drugs? Yes No Which ones? _____ Quit/When? _____

Have you ever had a blood transfusion? Yes No If yes, when? _____

***Please bring any records to your Office Visit including Advance Directive, Immunization, Colonoscopy, and Mammography.**



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Date of Birth _____

FAMILY HISTORY: INDICATE WHICH RELATIVE HAS HAD THE FOLLOWING DISEASES

	Mother	Father	Sister	Brother	Other	Reason
Deceased: List Age						

Disease	Check all that apply					Comments/Age of Onset
Coronary Heart Disease						
Depression						
Diabetes						
Hypertension						
Alcoholism						
ADHD						
Asthma						
Autism						
Cancer (specify):						
Celiac Disease						
COPD						
Bleeding Disorders						
Anemia						
Arthritis						
Anxiety						
CVA/Stroke						
Dementia						
Thyroid Disorder						
Headaches						
Growth/Development Disorder						
Liver Disease						
Osteoporosis						
Peptic Ulcer Disease						
Respiratory Disease						
Seizure Disorder						
Substance Abuse						

PLEASE CONTINUE TO NEXT PAGE



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REVIEW OF SYSTEMS: Check any of the following symptoms you have experienced **WITHIN THE PAST YEAR.**

<p>GENERAL:</p> <p><input type="checkbox"/> Change in Heat & Cold Tolerance</p> <p><input type="checkbox"/> Persistent Fever</p> <p><input type="checkbox"/> Chills/Cold Intolerance</p> <p><input type="checkbox"/> Excess Appetite</p> <p><input type="checkbox"/> Increased Thirst</p> <p><input type="checkbox"/> Lack of Appetite</p> <p><input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> Swollen Glands</p> <p><input type="checkbox"/> Unusual Weakness</p> <p><input type="checkbox"/> Unusual Fatigue</p> <p><input type="checkbox"/> Weight Change Increase _____ Decrease _____</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p> <p>ALLERGY:</p> <p><input type="checkbox"/> Sneezing</p> <p><input type="checkbox"/> Environmental Allergy</p> <p><input type="checkbox"/> Food Allergy _____</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p> <p>SKIN:</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Bruise Easily</p> <p><input type="checkbox"/> Change in Skin or Mole</p> <p><input type="checkbox"/> Dryness of Skin</p> <p><input type="checkbox"/> Rash or Hives</p> <p><input type="checkbox"/> Nail Change</p> <p><input type="checkbox"/> Unusual Hair Loss</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p> <p>EYES:</p> <p><input type="checkbox"/> Eye Pain</p> <p><input type="checkbox"/> Blind Spells (In One Eye)</p> <p><input type="checkbox"/> Change In Vision</p> <p><input type="checkbox"/> Contact Lenses</p> <p><input type="checkbox"/> Eye Infection</p> <p><input type="checkbox"/> Wear Glasses</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p>	<p>EARS/NOSE/THROAT:</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Hearing Loss</p> <p><input type="checkbox"/> Ear Infection Or Drainage</p> <p><input type="checkbox"/> Ringing In Ears</p> <p><input type="checkbox"/> Bleeding Gums</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Neck Swelling/Lumps</p> <p><input type="checkbox"/> Sores In Mouth</p> <p><input type="checkbox"/> Nose Bleeds</p> <p><input type="checkbox"/> Nasal Polyps</p> <p><input type="checkbox"/> Sinus Trouble</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p> <p>BREASTS:</p> <p><input type="checkbox"/> Discharge/Bleeding</p> <p><input type="checkbox"/> Nipple Changes</p> <p><input type="checkbox"/> Lump</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p> <p>HEART:</p> <p><input type="checkbox"/> White, Blue or Purple Discoloration of Hands or Feet</p> <p><input type="checkbox"/> Calf Pain When Walking</p> <p><input type="checkbox"/> Chest Discomfort/Pain</p> <p><input type="checkbox"/> Irregular Heart Beat</p> <p><input type="checkbox"/> Racing or Fluttering Heart</p> <p><input type="checkbox"/> Swollen Feet or Ankles</p> <p><input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p> <p>LUNGS:</p> <p><input type="checkbox"/> Shortness Of Breath</p> <p><input type="checkbox"/> Persistent Cough</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Cough Up Blood</p> <p><input type="checkbox"/> Cough Up Phlegm</p> <p><input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p>	<p>GASTROINTESTINAL:</p> <p><input type="checkbox"/> Belching</p> <p><input type="checkbox"/> Bloody or Black Stools</p> <p><input type="checkbox"/> Change in Stools</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Difficult Swallowing</p> <p><input type="checkbox"/> Excessive Gas</p> <p><input type="checkbox"/> Food Intolerance</p> <p><input type="checkbox"/> Heartburn/Esophageal Reflux</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Loose Bowels/Diarrhea</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Recurrent Abdominal Pain</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p> <p>URINARY:</p> <p><input type="checkbox"/> Change in Urinary Stream</p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Difficulty Urinating</p> <p><input type="checkbox"/> Frequency</p> <p><input type="checkbox"/> Leaking Urine</p> <p><input type="checkbox"/> Pain or Burning on Urination</p> <p><input type="checkbox"/> Unusually Large Volumes of Urine</p> <p><input type="checkbox"/> Up at night to urinate? How often? _____</p> <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Sexual Difficulty</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p> <p>FEMALE:</p> <p><input type="checkbox"/> Heavy Menstrual Bleeding</p> <p><input type="checkbox"/> Irregular Menstrual Periods</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Premenstrual Symptoms</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p>	<p>BONES AND JOINTS:</p> <p><input type="checkbox"/> Back or Neck Pain</p> <p><input type="checkbox"/> Cramps in Muscles</p> <p><input type="checkbox"/> Painful or Stiff Joints</p> <p><input type="checkbox"/> Pain Down Backs Of Legs</p> <p><input type="checkbox"/> Pain in Legs With Walking</p> <p><input type="checkbox"/> Swelling in Legs</p> <p><input type="checkbox"/> Redness of Joints</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p> <p>MOOD/MENTAL HEALTH:</p> <p><input type="checkbox"/> Depressed or Sad</p> <p><input type="checkbox"/> Irritable or Angry</p> <p><input type="checkbox"/> Anxious, Tense, or Worried</p> <p><input type="checkbox"/> Fearful</p> <p><input type="checkbox"/> Sleep Problems</p> <p><input type="checkbox"/> Loss of Interest in Activities</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Suicidal Thoughts</p> <p><input type="checkbox"/> Compulsive Behaviors</p> <p><input type="checkbox"/> Concentration/Memory Problems</p> <p><input type="checkbox"/> Marital, Family or Work Problems</p> <p><input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p> <p>NEUROLOGIC:</p> <p><input type="checkbox"/> Coordination Problems</p> <p><input type="checkbox"/> Difficulties in Speaking</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting Spells</p> <p><input type="checkbox"/> Frequent Headaches</p> <p><input type="checkbox"/> Loss of Balance</p> <p><input type="checkbox"/> Loss of Sensation</p> <p><input type="checkbox"/> Muscle Weakness</p> <p><input type="checkbox"/> Numbness or Tingling</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the Above</p>
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FOR CLINICIAN USE ONLY	
Reviewed by: _____	Date: _____