



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> <ul style="list-style-type: none"> <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Abdominal Aortic Aneurysm <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Aortic Valve Disorder <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Hypertension <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Deep Vein Thrombosis (DVT) <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Heart Valve – Artificial <input type="checkbox"/> Heart Valve – Disorder <input type="checkbox"/> Other _____ <p>INFECTIOUS DISEASE:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Other _____ <p>MUSCULOSKELETAL:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia | <p><input type="checkbox"/> Osteopenia</p> <p><input type="checkbox"/> Osteoporosis</p> <p>RESPIRATORY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies <input type="checkbox"/> Chronic Obstructive Pulmonary Disease <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other _____ <p>GASTROINTESTINAL:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Gastric Ulcers <input type="checkbox"/> Hepatitis, Type _____ <input type="checkbox"/> GERD <input type="checkbox"/> Other _____ <p>KIDNEY/BLADDER:</p> <ul style="list-style-type: none"> Benign Prostate Hypertrophy <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Hypogonadism <input type="checkbox"/> Incontinence – Urinary | <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> <ul style="list-style-type: none"> <input type="checkbox"/> Pap – Abnormal <input type="checkbox"/> Other _____ <p>MENTAL HEALTH/NEUROLOGIC:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Depression <input type="checkbox"/> Cerebral Vascular Accident (CVA) <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anxiety <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Insomnia <input type="checkbox"/> Migraine <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Attention Deficit Disorder (ADD) <input type="checkbox"/> Other _____ | <p>METABOLIC/NUTRITION:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Anemia <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Impaired Fasting Glucose <input type="checkbox"/> Obesity <input type="checkbox"/> Vitamin B12 Deficiency <input type="checkbox"/> Vitamin D Deficiency <input type="checkbox"/> Other _____ <p>CANCER:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Cancer – Melanoma <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Other Cancer: _____ |
|--|---|---|---|

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)

1. _____	Date: _____	3. _____	Date: _____
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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Today's Date _____

Patient Name _____

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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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page 4

Today's Date _____

Patient Name _____

Date of Birth _____

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

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

FOR CLINICIAN USE ONLY

Reviewed by: _____ Date: _____