



Welcome! This form helps us to meet your medical needs and to provide the best service to you. If you have any questions or need assistance, please ask us.

GENERAL PATIENT INFORMATION

First Name: _____ Middle: _____ Last: _____ Home Phone: _____
 Date of Birth: _____ Sex at Birth: Female Male Cell Phone: _____
 Address: _____ Work Phone: _____
 City: _____ State: _____ Zip: _____ E-mail: _____
 Preferred Method of Contact: Home Cell Work E-mail Occupation: _____

EMERGENCY CONTACT INFORMATION

Contact #1 Name: _____ Contact #2 Name: _____
 Relationship to You: _____ Relationship to You: _____
 Contact #1 Phone: _____ Contact #2 Phone: _____
 Home Cell Work Home Cell Work

INSURANCE ASSIGNMENT AND RELEASE

Please make sure we have a copy of your insurance card.

I hereby authorize payment directly to MEDNORTHWEST for all insurance benefits otherwise payable to me for services rendered. I am responsible for all charges not covered by insurance.

Signature: _____ Date: _____

What brings you into the office today? _____

This form is long! Please feel free to have the doctor or medical staff help you to complete it if you need any assistance at all.

CURRENT HEALTH SUMMARY

Please list any current medical issues, the date you first noticed the issue, and the name and specialty of the physician who treated you (if any):

Current Medical Concerns	Date of Onset	Physician's Name	Specialty

List any current medications, including over-the-counter drugs, aspirin, vitamins and herbal preparations. I am on no medications.

Medication Name	Pill Size	How Taken	Medication Name	Pill Size	How Taken

FAMILY MEDICAL HISTORY

A "close relative" is a brother, sister, mother, father, or child. However, please consider any other relatives where you feel it may be helpful.

Do you have a **family history** of heart attacks, stents, or bypass surgery? Yes No

If yes, please list relative(s), type of heart disease, and the age when symptoms started.

Have any of your **close relatives** had a history of stroke? Yes No

If yes, please list the relative(s), and the age at which the stroke first occurred.

Do you have a **family history** of colon polyps or colon cancer? Yes No

If yes, please list the relative(s), type of colon issue, and the age when symptoms first appeared.

Do you have a **family history** of diabetes? Yes No

If yes, please list the relative(s) and the age at which diabetes first developed.

Has anyone in your **family** had Alzheimer's Disease? Yes No

If yes, please list the relative(s) and the age at which memory problems first occurred.

Is there a **family history** of mental health problems that you feel is relevant? Yes No

If yes, please list the relative(s) and describe the type of problem.

Did you have a **close relative** with prostate cancer? (*male patients only*) Yes No

If yes, please list the relative(s) and the age at which it first occurred.

Do you have a **close relative** with osteoporosis or fractures? Yes No

If yes, please list the family member(s), the type of fracture, and the age at which it first occurred.

Any **close relatives** with a history of breast cancer or ovarian cancer? Yes No

If yes, please list the family member(s), the type of cancer, and the age at which it first occurred.

Have any **relatives** been tested for the BRCA-1 or BRCA-2 genes? Yes No

If yes, what were the results?

If you have other **family** health history that you feel is relevant describe the type of disease and the age at which symptoms first occurred.

ALLERGY INFORMATION

List any allergies you have in the table below. I have no allergies of any kind.

Food, Medication, or Insect	Reaction	Food, Medication, or Insect	Reaction

Additionally, please check if you are allergic to any of the following: Shellfish Contrast (Dye) Latex

VACCINATION HISTORY

Vaccine	Date	Vaccine	Date
Tetanus		Hepatitis A	
Flu Shot		Hepatitis B	
Pneumovax (pneumonia)		Gardasil (HPV)	
Prevnar (PVC13)		Other (?)	
Zostavax (shingles)		Other (?)	

SURGICAL HISTORY

Surgery or Procedure	Date	Name of Surgeon	Outcome

HEALTH MAINTENANCE

Please enter the date of your last:	Date	Female patients only:	Date
Colonoscopy		When was your last mammogram?	
Bone density scan (DEXA)		When was your last pap smear?	
Treadmill test (stress test)		Have you ever had an abnormal pap?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary calcium score		If yes, when was it?	
Annual exam		Did you undergo treatment? (please explain)	
Ultrasound test for aortic aneurysm			
PSA (male patients only)			

REVIEW OF SYSTEMS

In the last six months, have you experienced any of the following?

<p>Constitutional</p> <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Unexplained fever <input type="checkbox"/> None of these	<p>Genitourinary (Men)</p> <input type="checkbox"/> Slow urine stream <input type="checkbox"/> Up more than once per night to urinate <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Trouble getting or maintaining erections <input type="checkbox"/> Lump or mass in the testicles <input type="checkbox"/> Hernia <input type="checkbox"/> Any sexual concerns <input type="checkbox"/> None of these	<p>Respiratory</p> <input type="checkbox"/> Asthma or wheezing <input type="checkbox"/> Emphysema (COPD) <input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> None of these
<p>Eyes</p> <input type="checkbox"/> Difficulty with vision <input type="checkbox"/> History of eye surgery <input type="checkbox"/> Glaucoma <input type="checkbox"/> None of these	<p>Genitourinary (Women)</p> <p>How many children have you had? _____</p> <input type="checkbox"/> Leakage of urine? <input type="checkbox"/> Heavy or irregular periods <input type="checkbox"/> Vaginal pain, soreness, or dryness <input type="checkbox"/> Blood in urine <input type="checkbox"/> Hernia <input type="checkbox"/> Any sexual concerns <input type="checkbox"/> None of these <input type="checkbox"/> I had a hysterectomy ...if so do you still have your ovaries? _____	<p>Neurological</p> <input type="checkbox"/> Headaches <input type="checkbox"/> Trouble with short term memory <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness in the feet (neuropathy) <input type="checkbox"/> History of ADD or trouble with focusing? <input type="checkbox"/> None of these
<p>Ears, Nose, and Throat</p> <input type="checkbox"/> Sleepy during the day <input type="checkbox"/> Loud snoring at night <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Hearing loss <input type="checkbox"/> Frequent sinus or ear infections <input type="checkbox"/> None of these	<p>Allergic or Immunologic</p> <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Had chickenpox as a child <input type="checkbox"/> None of these	<p>Psychiatric</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Panic attacks <input type="checkbox"/> Specific fears (driving, elevators, etc) <input type="checkbox"/> Thoughts of hurting or killing yourself <input type="checkbox"/> History of substance abuse <input type="checkbox"/> Prior suicide attempt <input type="checkbox"/> Psychiatric hospitalization <input type="checkbox"/> Bipolar Illness <input type="checkbox"/> None of these
<p>Heart</p> <input type="checkbox"/> Born with a heart defect <input type="checkbox"/> Have a pacemaker <input type="checkbox"/> Heart murmur <input type="checkbox"/> Take antibiotics before dental work <input type="checkbox"/> Heart valve problems <input type="checkbox"/> High blood pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Stroke or TIA <input type="checkbox"/> Abnormal Heart Rhythm <input type="checkbox"/> None of these	<p>Musculoskeletal</p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Other joint pains <input type="checkbox"/> History of fractures. If so, what kind? _____ <input type="checkbox"/> None of these	<p>Endocrine</p> <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Severe menopausal symptoms <input type="checkbox"/> Diabetes <input type="checkbox"/> Low testosterone <input type="checkbox"/> None of these

REVIEW OF SYSTEMS (continued from the previous page)

In the last six months, have you experienced any of the following?

<p>Hematologic</p> <input type="checkbox"/> Easy bleeding after surgery or dental work (ever in your life)	<p>Gastrointestinal</p> <input type="checkbox"/> Hepatitis
<input type="checkbox"/> History of anemia (low blood count)	<input type="checkbox"/> Other liver disease
<input type="checkbox"/> Iron deficiency	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> None of these	<input type="checkbox"/> Heartburn
<p>Skin/Breast</p> <input type="checkbox"/> Breast lump or mass	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Unusual mole	<input type="checkbox"/> Unexplained abdominal pain
<input type="checkbox"/> Skin cancer	<input type="checkbox"/> Trouble swallowing solids or liquids
<input type="checkbox"/> None of these	<input type="checkbox"/> Sensitivity to milk products
<p>Oncology (Cancer)</p> <input type="checkbox"/> History of any type of cancer? If so, what kind? _____ _____	<input type="checkbox"/> Wheat allergy
	<input type="checkbox"/> Diverticulitis
	<input type="checkbox"/> Polyps
	<input type="checkbox"/> None of these

TOBACCO, ALCOHOL, CAFFEINE, AND DRUG USE HISTORY

Have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ # packs / day	_____ # of years	When did you quit? _____
Do you chew tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
How many alcoholic drinks do you have in a typical week?	_____ # of drinks		
Did you drink more heavily in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has anyone ever suggested that you cut down your drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
How many cups of coffee do you drink daily?	_____ # of drinks		
Any recreational drug use (marijuana, cocaine, and so forth)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>If yes, please describe:</i>			

PERSONAL SAFETY

Please check all that apply:	
<input type="checkbox"/> I have a smoke detector in my home.	<input type="checkbox"/> I wear a seat belt.
<input type="checkbox"/> I have a carbon monoxide detector at home.	<input type="checkbox"/> I have a living will.
<input type="checkbox"/> I use a cell phone while driving. (This is equally dangerous with or without a headset.)	<input type="checkbox"/> I have a history of multiple falls
	<input type="checkbox"/> I feel threatened by or afraid of someone close to me.
<input type="checkbox"/> I keep firearms in my house. (If the answer is yes, we urge you to keep them locked or inside a locked compartment.)	<input type="checkbox"/> I have a durable power of attorney for health care. (That person is _____.)

