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**

HEART/VASCULAR DISEASE:
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Abdominal Aortic Aneurysm
- ☐ Congestive Heart Failure
- ☐ Aortic Valve Disorder
- ☐ Atrial fibrillation
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Peripheral Vascular Disease
- ☐ Heart Valve — Artificial
- ☐ Heart Valve — Disorder
- ☐ Other _____

INFECTIOUS DISEASE:
- ☐ Other _____

MUSCULOSKELETAL:
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Osteopenia
- ☐ Osteoporosis

RESPIRATORY:
- ☐ Asthma
- ☐ Allergies
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Sleep Apnea
- ☐ Other _____

GASTROINTESTINAL:
- ☐ Gastric Ulcers
- ☐ Hepatitis, Type _____
- ☐ GERD
- ☐ Other _____

KIDNEY/BLADDER:

Benign Prostate Hypertrophy
- ☐ Erectile Dysfunction
- ☐ Chronic Kidney Disease
- ☐ Hypogonadism
- ☐ Incontinence — Urinary
- ☐ Kidney Stones
- ☐ Overactive Bladder
- ☐ PSA — Elevated
- ☐ Other _____

GYNECOLOGICAL:
- ☐ Pap — Abnormal
- ☐ Other _____

MENTAL HEALTH/ NEUROLOGIC:
- ☐ Depression
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Drug Abuse
- ☐ Insomnia
- ☐ Migraine
- ☐ Neuropathy
- ☐ Parkinson's Disease
- ☐ Attention Deficit Disorder (ADD)
- ☐ Other _____

METABOLIC/NUTRITION:
- ☐ Diabetes
- ☐ Anemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Impaired Fasting Glucose
- ☐ Obesity
- ☐ Vitamin B12 Deficiency
- ☐ Vitamin D Deficiency
- ☐ Other _____

CANCER:
- ☐ Breast Cancer
- ☐ Lung Cancer
- ☐ Cancer — Melanoma
- ☐ Colon Cancer
- ☐ Skin Cancer
- ☐ Prostate Cancer
- ☐ Other Cancer:

_____

_____

PLEASE CONTINUE TO NEXT PAGE

Oregon Medical Group New Patient Medical History Form

page 2

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
☐ Appendectomy		☐ Amputation		☐ Craniotomy	
☐ Gall Bladder Removal		☐ Colon Resection		☐ Gastric Bypass	
☐ Heart Surgery (specify)		☐ Nephrectomy		☐ Knee Arthroscopy	
☐ Back/Neck Surgery		☐ Prostatectomy		☐ Carotid Endarterectomy	
☐ Knee/Hip Replacement		☐ Pacemaker		☐ Shoulder Surgery	
☐ Thyroidectomy		☐ Cataract		☐ Tonsillectomy	
☐ Hemorrhoidectomy		☐ Carpal Tunnel		☐ Vertebroplasty	

☐ 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.**

PLEASE CONTINUE TO NEXT PAGE

Oregon Medical Group New Patient Medical History Form

page 3

Today's Date _____

Patient Name _____

Date of Birth _____

FAMILY HISTORY: INDICATE WHICH RELATIVE HAS HAD THE FOLLOWING DISEASES

Deceased: List Age	Mother	Father	Sister	Brother	Other	Reason
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**.

GENERAL:
- ☐ Change in Heat & Cold Tolerance
- ☐ Persistent Fever
- ☐ Chills/Cold Intolerance
- ☐ Excess Appetite
- ☐ Increased Thirst
- ☐ Lack of Appetite
- ☐ Night Sweats
- ☐ Swollen Glands
- ☐ Unusual Weakness
- ☐ Unusual Fatigue
- ☐ Weight Change
  - Increase _____
  - Decrease _____
- ☐ Other _____
- ☐ **None of the Above**

ALLERGY:
- ☐ Sneezing
- ☐ Environmental Allergy
- ☐ Food Allergy _____
- ☐ Other _____
- ☐ **None of the Above**

SKIN:
- ☐ Ulcers
- ☐ Bruise Easily
- ☐ Change in Skin or Mole
- ☐ Dryness of Skin
- ☐ Rash or Hives
- ☐ Nail Change
- ☐ Unusual Hair Loss
- ☐ Other _____
- ☐ **None of the Above**

EYES:
- ☐ Eye Pain
- ☐ Blind Spells (In One Eye)
- ☐ Change In Vision
- ☐ Contact Lenses
- ☐ Eye Infection
- ☐ Wear Glasses
- ☐ Other _____
- ☐ **None of the Above**

EARS/NOSE/THROAT:
- ☐ Earache
- ☐ Hearing Loss
- ☐ Ear Infection Or Drainage
- ☐ Ringing In Ears
- ☐ Bleeding Gums
- ☐ Hoarseness
- ☐ Neck Swelling/Lumps
- ☐ Sores In Mouth
- ☐ Nose Bleeds
- ☐ Nasal Polyps
- ☐ Sinus Trouble
- ☐ Other _____
- ☐ **None of the Above**

BREASTS:
- ☐ Discharge/Bleeding
- ☐ Nipple Changes
- ☐ Lump
- ☐ Pain
- ☐ Other _____
- ☐ **None of the Above**

HEART:
- ☐ White, Blue or Purple Discoloration of Hands or Feet
- ☐ Calf Pain When Walking
- ☐ Chest Discomfort/Pain
- ☐ Irregular Heart Beat
- ☐ Racing or Fluttering Heart
- ☐ Swollen Feet or Ankles
- ☐ Varicose Veins
- ☐ Other _____
- ☐ **None of the Above**

LUNGS:
- ☐ Shortness Of Breath
- ☐ Persistent Cough
- ☐ Wheezing
- ☐ Cough Up Blood
- ☐ Cough Up Phlegm
- ☐ Difficulty Breathing
- ☐ Other _____
- ☐ **None of the Above**

GASTROINTESTINAL:
- ☐ Belching
- ☐ Bloody or Black Stools
- ☐ Change in Stools
- ☐ Constipation
- ☐ Difficult Swallowing
- ☐ Excessive Gas
- ☐ Food Intolerance
- ☐ Heartburn/Esophageal Reflux
- ☐ Hemorrhoids
- ☐ Loose Bowels/Diarrhea
- ☐ Nausea
- ☐ Recurrent Abdominal Pain
- ☐ Vomiting
- ☐ Other _____
- ☐ **None of the Above**

URINARY:
- ☐ Change in Urinary Stream
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Frequency
- ☐ Leaking Urine
- ☐ Pain or Burning on Urination
- ☐ Unusually Large Volumes of Urine
- ☐ Up at night to urinate?
  - How often? _____
- ☐ Incontinence
- ☐ Sexual Difficulty
- ☐ Other _____
- ☐ **None of the Above**

FEMALE:
- ☐ Heavy Menstrual Bleeding
- ☐ Irregular Menstrual Periods
- ☐ Discharge
- ☐ Premenstrual Symptoms
- ☐ Other _____
- ☐ **None of the Above**

BONES AND JOINTS:
- ☐ Back or Neck Pain
- ☐ Cramps in Muscles
- ☐ Painful or Stiff Joints
- ☐ Pain Down Backs Of Legs
- ☐ Pain in Legs With Walking
- ☐ Swelling in Legs
- ☐ Redness of Joints
- ☐ Other _____
- ☐ **None of the Above**

MOOD/MENTAL HEALTH:
- ☐ Depressed or Sad
- ☐ Irritable or Angry
- ☐ Anxious, Tense, or Worried
- ☐ Fearful
- ☐ Sleep Problems
- ☐ Loss of Interest in Activities
- ☐ Fatigue
- ☐ Suicidal Thoughts
- ☐ Compulsive Behaviors
- ☐ Concentration/Memory Problems
- ☐ Marital, Family or Work Problems
- ☐ Stress
- ☐ Other _____
- ☐ **None of the Above**

NEUROLOGIC:
- ☐ Coordination Problems
- ☐ Difficulties in Speaking
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Loss of Balance
- ☐ Loss of Sensation
- ☐ Muscle Weakness
- ☐ Numbness or Tingling
- ☐ Other _____
- ☐ **None of the Above**

FOR CLINICIAN USE ONLY

Reviewed by: **Date:**