# Providence Medical Group – Mary's Woods

**Patient Name:** ______________________________________ **Date of Birth:** ______/______/______

**Preferred Name:** ____________________________________ **Gender at Birth:** Male / Female (circle one)

**Gender Identity:** Male / Female / Other (circle one) **Prounouns:** she, her / he, him / they, them (circle one)

**Marital Status:** ________________________ **Occupation:** ____________________

**Do you reside in Assisted Living/Memory Care/Foster Home?** Yes / No (circle one)

Name of Facility: _________________________________________________

Address of Facility: ________________________________________________

Phone: _________________________ Fax: ________________________

Name of Contact: _________________________________________________

**Have you completed and Advance Directive or POLST?** Yes / No (circle one)

**Have you been seen at the following for any type of visit, treatment, testing or hospitalization?**

(circle all that apply) OHSU Adventist Health Legacy Kaiser Other: ______________

**Preventative Services:** **(Please List when and where the procedure was done)**

Colonoscopy: ____________________

Female: Pap test: _________________ Female: Mammogram: ______________

**Current Medications:** **(Please bring current medication list or complete section below)**

| Medication | Dose | Frequency | When Started? |
|---|---|---|---|
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**List all surgeries and serious illness:**

| Surgery/Serious Illness | Year | Hospital/Any Complications |
|---|---|---|
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**Please circle any new or worrisome symptoms (In the past 4 weeks):**

| | |
|---|---|
| **General:** Fever/chills, Weight Loss/Gain | **Genitourinary:** Blood in urine |
| **HEENT:** Sore throat, runny nose, vision change | **Neuro:** Numbness, tingling, dizziness, lightheadedness |
| **Skin:** Rashes, easy bruising | **Gastrointestinal:** Nausea, vomiting, diarrhea, constipation, blood in stool |
| **Pulmonary:** Shortness of breath, wheezing, coughing | **Musculoskeletal:** Joint pain, joint swelling |
| **Cardiac:** Palpitations, chest pain | **Mental health**: Depression, Anxiety |
| **Extremities:** Swelling | **Other:** |

**Medical History: Have you every had: (Circle all that apply)**

Anemia
Anxiety
Arthritis
Asthma
Blood Transfusion
Cancer
Cataracts
Clotting Disorder
Congestive Heart Failure
COPD (constructive obstructive pulmonary disease)
Other: __________________

Depression
Diabetes
Emphysema
Environmental Allergies
Glaucoma
Heart Attack
Heart Murmur
High Blood Pressure
HIV/AIDS
Hyperlipidemia

Kidney Disease
Meningitis
Nerve/Muscle disease
Osteoporosis
Reflux
Seizures
Sickle Cell Anemia
Stroke
Substance Abuse
Tuberculosis

**Family History:**

Major medical problems that would be worrisome for your own medical risk including mental health, cardiovascular, diabetes, and cancer.

| | **Age** | **Living** | **Age at Death** | **Cause of Death or Current Condition** |
|---|---|---|---|---|
| Mother | _______ | Yes/No | _______ | __________________________________ |
| Father | _______ | Yes/No | _______ | __________________________________ |
| Brother(s) | _______ | Yes/No | _______ | __________________________________ |
| Sister(s) | _______ | Yes/No | _______ | __________________________________ |