Welcome to Providence Medical Group Gresham. Your provider has asked that you fill this NEW PATIENT HISTORY FORM

Name ____ Date of Birth __________________________

Have you ever been seen at the following for any type of visits including primary care, immediate care, ER, or hospitalizations + as well as any blood work and imaging studies such as ultrasounds and X-rays CTs MRIs , Xrays:

OHSU Adventist Health Legacy Kaiser

In addition to establishing care with us at Providence Medical Group, how can we help?
______Review prescriptions + chronic problems (medications often won't be refilled if not reviewed with provider)
______**OR** Get A Physical
______**OR** Discuss acute new concerns

Do you need any medication refilled, referrals, forms completed, or a letter for work? **Y** **N** **N/A**

Preventive Screening: please list which health system or medical group it was done through (such as the Oregon Clinic)

If age over 50, have you had a colonoscopy in the past 10 years? Y N N/A
If age over 50 + female, have you had a mammogram in last 2 years? Y N N/A
If age over 21 + female, have you had a pap in the past 3 years? Y N N/A

For a new problem evaluation: what is the chief symptom and when did it start, are there other associated symptoms? Any other details or concerns?
1.____
____
____
2.____
____
____

For Current Medical problems (Active) and what medications do you take for it:
1.____
2.____
3.____
4.____
5. ____

Current Medications and dose (Active ones. Including "as needed" and supplements)
1.____ 5. ____
2. ____ 6. ____
3. ____ 7. ____
4. ____ 8. ____

Do you see any specialists now or in the past? What specialty? Who was it? When was the last time you saw them? What do they treat for you? What medications do they prescribe?
1. ____
2. ____

Review of Systems (circle all that apply within the past 4 weeks)
General: fatigue, fevers
Vision: double vision
Head & Neck: change in hearing, ear pain
Pulmonary: wheezing
Cardiac: chest pain, rapid heartbeat
Gastrointestinal: nausea or vomiting
GU: blood in urine
Hematology: abnormal bleeding
Neuro: seizures, loss of consciousness
Endocrine: fatigue, high level of thirst
Musculoskeletal: joint swelling
Mental health: anxiousness, memory problems
Skin & Hair: sores that grow

PROVIDENCE Medical Group Gresham

Allergies (Please include reaction):

1. ____ 2. ____

Past Medical History:

Past Medical Problems that are now resolved:
What was it / When did it resolve / how did it resolve:
1. ____
2. ____

Hospitalizations (outside of surgeries and pregnancies, not ER visits)
What was it for, what did they diagnosis – year – any complications?
1. ____
2. ____

Surgery History:
Type of surgery , for what? – year?– any complications?
1. ____ 3. ____
2. ____ 4. ____

Family History:
Major medical problems that would be worrisome for your own medical risk including mental health, or are they generally healthy and well. If passed away, what was their **cause** of death and **age**?
Mother's **First Name PLEASE**: _____________________ Father's **First Name PLEASE**:______________________
sisters ___ # brothers ___ : **Names PLEASE**
1. ____ 4. ____
2. ____ 5. ____
3. ____ 6. ____

Is there any history of diabetes? Yes or No Who?
Is there any family history of early cardiovascular disease (heart attack, stroke, mini-stroke) in males under the age of 55, or females under the age of 65? Yes or No Who?
Is there any family history of cancer? Yes or No If so, who and what type?
1. ____ 3. ____
2. ____ 4. ____

If you use tobacco or used in the past, when did you start and when did you quit. How many packs or cans did you "average" over that period of time?
____
Drug Abuse (if so, what and when)____
Alcohol Use (how many drinks per week average):____

Social history: What do you do for a living (describe job responsibility)? If not working now, what did you do in the past?
____ If married or with domestic partner, what year were you married and to whom?_________________________________ How many children (age and DOB)____ What level or how many years of education do you have? Some college? AA? Bachelors? Technical degree?

Hobbies: 3 things you enjoy doing or have a passion for, or something unique

1.__________________________ 2. __________________________ 3. __________________________

For Females:
How many times have you been pregnant?________ How many children did you give birth to?_________