PROVIDENCE
Medical Group
Newberg

Providence Medical Group Newberg

Primary Care Provider
Medical History

Patient Name: _____Date: _____
Last First Middle

Preferred Name: _____

DOB: _____ Age: _____ Sex: ____Male____Female
Month Day Year

Last Doctor/Clinic: _____

Who referred you to Providence Medical Group Newberg?_____

Past Medical History

Do you have a history of any of the following conditions? Please check all that apply:

____ High Blood Pressure	____ Acid Reflux/Indigestion	____ Seizure Disorder
____ Diabetes (Type 1 or 2) _____ Eye Complications _____ Kidney Complications _____ Nerve Complications _____ Other_____	____ Other Stomach History Type _____ _____ _____ _____	____ Stroke Type _____ _____ _____ _____
____ Heart Disease ____ Coronary Disease ____ Heart Attack ____ Heart Failure ____ Arrhythmia ____ Other_____	____ Sleep Disorder ____ Sleep Apnea ____ Restless Legs ____ Insomnia	____ Migraines ____ Depression ____ Anxiety ____ Memory Loss
____ High Cholesterol	____ Alcohol Abuse	____ Drug Abuse
____ Kidney Disease Type_____ Type_____	____Thyroid Disorder Type_____ Type_____	____ Anemia ____ Bleeding Problems ____ Blood Clots
____ Lung Disease ____ Asthma ____ COPD ____ Emphysema ____ Other_____ ____ Other_____	____Arthritis ____ Osteoarthritis ____ Rheumatoid Location_____ _____ _____	____ Cancer Type_____ Location_____ Remission or Current Type_____ Location_____ Remission or Current
____ Unexplained Weight Loss ____ Skin Disorder	____ Osteoporosis	____ Recurrent Infections Location_____ _____

Other: (Please Specify) _____

_____

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Surgical History

Surgery	Reason	Appx. Date	Age

Hospitalizations

Reason	Location	Appx. Date	Age

Medications (Prescriptions)

Drug Name	Dose (i.e. 10 mgs.)	Frequency (i.e. twice daily)

Over the Counter Medications (OTC)

Drug Name	Dose (i.e. 10 mgs.)	Frequency (i.e. twice daily)

Allergies to Medications

Drug Name	Allergic Reaction (hives etc.)

Other Allergies

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Allergen (peanuts, dust etc.)	Allergic Reaction (hives etc.)

Specialists Involved in Your Healthcare (pulmonologist [lung doctor], cardiologist [heart doctor])

Physician Name	Specialty

Family History (mother, father, siblings, etc.)

Name	Relationship	Age	Age at Death	Medical Problems

Preventative/Safety

Immunizations	Date	Screening Tests	Date
Tetanus Tdap		Colonoscopy	
Pneumovax		Bone Density	
Flu		Mammogram	
Hepatitis A		Pap Smear	
Hepatitis B			
Zoster (shingles)			

Menstrual History (Women Only)

First Menstrual Period	Date:_____	Last Menstrual Period	Date:_____	
Last Pap Smear	Date:_____	History of Abnormal PAP:	Yes	No
Number of Pregnancies	#_____	Pregnancy Complications	Yes	No
Number of Miscarriages	#_____	History of Bleeding Problem	Yes	No
Number of Children	#_____	Age at Onset of Menopause	_____	
Number of Abortions	#_____			

Social History

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Marital Status: Single Married Remarried Separated Divorced Widowed

Do you have any concerns regarding any of your current relationships?_____

Who lives with you?_____

Your current occupation:_____

List your former occupation(s):_____

Current occupation of spouse:_____

Have you ever smoked? Yes No Do you currently smoke? Yes No

If yes, how many packs per day? _____ At what age did you start smoking?_____

If you have been a smoker in the past and have quit, when did you quit?_____

Do you use chewing tobacco? Yes No Have you used any illegal substances? Yes No

Do you drink alcohol? Yes No

If yes, what is the average number of drinks consumed per week? 1-5 6-10 11-20 +20

Compared to last year, are you drinking _____More _____Less _____About the same?

In the last year, have you been concerned about your alcohol intake? Yes No

What is your current level of <u>weekly</u> exercise?

____ None ____ Daily ____ Active, but no exercise ____ less than 3X ____ more than 3X

Do you have specific hobbies? If yes, please list:_____

_____

Do you follow a special diet? If yes, please describe or list:_____

_____

Do you wear your seatbelt regularly? Yes No

Do you have spiritual beliefs or practices that are important to you? If yes, please describe:_____

_____

_____

<u>Concerns</u>

We are honored that you have chosen Providence Medical Group (PMG) Newberg to participate in optimizing your health and quality of life. We consider it a privilege and will do our very best to serve you and all of your health care needs.

We know there may be many concerns that you bring with you regarding your health, and we want the opportunity to address each of them. If you have specific concerns that you would like to make sure we address during your initial visit, please let us know by using the space below. Listing your concerns and/or questions in order of importance will help in properly utilizing the time allotted for your visit. If additional time is needed, we can make arrangements to see you again in the near future.

_____

_____

_____

_____

_____

"Thank you" for choosing Providence Medical Group Newberg for your healthcare needs.