Providence Medical Group Scholls
12442 SW Scholls Ferry Road
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Phone: 503 216-9200

Welcome to Providence Medical Group Scholls

Name: _____ Date of Birth: _____ Today's Date: _____
Preferred Name & Pronoun (if different): _____

Welcome to PMG Scholls! You're here because your health is important to you and we care about your health as well. Thank you for filling out this PRE-visit form so together we can provide the highest quality healthcare and best experience for you.

What is the **most important** issue for us to address at today's visit?

_____

_____

If we have time today, or for a future visit, what other concerns do you have?

1) _____
2) _____
3) _____

Do you need any medications **refilled, referrals, forms completed, or a letter for work** today? ☐ Yes ☐ No

Symptom Checklist: *Please check any that you've had within the past two weeks and continues.*

General: ☐Fatigue ☐Fevers ☐Unwanted weight changes ☐Always very thirsty ☐Always feeling too cold or hot

Eyes: ☐Blurry vision ☐Eye pain

Hearing: ☐Hearing loss ☐Ear pain

Lungs: ☐Shortness of breath ☐Cough

Heart: ☐Chest pain or pressure ☐Rapid heartbeat

Gastrointestinal: ☐Abdominal pain ☐Trouble swallowing ☐Vomiting ☐Bloody or black stools

Urinary: ☐Blood in urine ☐Loss of bladder control ☐Painful urination ☐Frequent or urgent urination

Blood: ☐Abnormal bleeding ☐Easy bruising

Nervous System: ☐Seizures ☐Passing out ☐Dizzy ☐Tremor ☐Problems moving ☐Numbness ☐Trouble walking

Immune System: ☐Uncontrolled allergies ☐Swollen lymph nodes ☐Frequent infections

Musculoskeletal: ☐Back or neck pain ☐Joint pain

Mental health: ☐Depression ☐Anxiety ☐Memory problems ☐Trouble sleeping ☐Suicidal thinking

Skin: ☐Changing skin moles ☐Rash

Women: ☐Breast lumps ☐Pelvic pain ☐Excessive bleeding

Men: ☐Testicular pain or lumps ☐ Other issues

Medications: Please list the name, strength, and frequency of the medication.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Drug Allergies: Please list the medication and type of reaction. If No Drug Allergies, check ☐ and skip this section.

1. _____
2. _____
3. _____
4. _____

PERSONAL MEDICAL HISTORY

Do you have or have you had in the past any of the following conditions?

- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Cataracts
- ☐ Heart Failure (CHF)
- ☐ Blood Clot
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Environmental Allergies
- ☐ Acid Reflux (GERD)
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Meningitis
- ☐ Heart Attack
- ☐ Nerve / Muscle Disease
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other _____

SURGICAL HISTORY

Have you had any of these surgeries or procedures?

- ☐ Appendectomy
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ Coronary Bypass (CABG)
- ☐ Gall Bladder Removal
- ☐ Colon Surgery
- ☐ Cosmetic Surgery
- ☐ C-Section
- ☐ Eye Surgery
- ☐ Fracture Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Prostatectomy
- ☐ Other _____
- ☐ Joint Replacement
- ☐ Small Intestine Surgery
- ☐ Spine Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Valve Replacement
- ☐ Other _____

FAMILY HISTORY

If ☐ Adopted or unknown.

Relationship	Name (optional)	Alive	No Known Problems	Arthritis	Breast Cancer	Colon Cancer	Cancer - Other	Clotting Disorder	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Liver Disease	Lung Disease	Mental Illness	Stroke	Substance Abuse	Other
Mother		Y N																	
Father		Y N																	
Sister(s)		Y N																	
Brother(s)		Y N																	
Daughter(s)		Y N																	
Son(s)		Y N																	
Mom's Sister(s)		Y N																	
Mom's Brother(s)		Y N																	
Dad's Sister(s)		Y N																	
Dad's Brother(s)		Y N																	
Mom's Mom		Y N																	
Mom's Dad		Y N																	
Dad's Mom		Y N																	
Dad's Dad		Y N																	

As best you can, mark which relative has had these diseases. The health of your parents, brothers, and sisters is most important.

SOCIAL HISTORY

Marital Status (if applicable): _____ Occupation: _____ Hobbies: _____

Are you sexually active? ☐ Yes ☐ No If yes, partners: ☐ Male ☐ Female

Do you use **tobacco** products? ☐ Yes -or- No: ☐ Never used tobacco ☐ Quit Date: _____

If Yes: How many packs/cans per day?_____ How many years?____ Are you interested in quitting? ☐ Yes ☐ No

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Alcohol: One drink =

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	○	○

Mood:	Not At All	Several Days	More Than One-Half The Days	Nearly Every Day
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○	○	○

PREVENTIVE HEALTH

For **women only:**

1. Last menstrual period - Date: _____
2. Are you currently breast feeding? ☐ Yes ☐ No
3. If sexually active with men:
   - Would you like to become pregnant in the next year? ☐ Yes ☐ No
   - Are you using contraception? ☐ Yes ☐ No

Effective Reversible Contraception		*Other Contraception*	
☐ Oral Birth Control	☐ Ring / Patch	☐ Hysterectomy	☐ Condoms
☐ IUD	☐ Nexplanon Implant	☐ Post-Menopause	☐ Sponge / Spermicide
☐ Depo Provera	☐ Tubal Ligation	☐ Vasectomy	☐ Other _____

Have you had a **Pap** in the past 3 years? ☐ Yes: Date _____ Location:_____ ☐ No

Have you had a **Mammogram** in the past 2 yrs? ☐ Yes: Date _____ Location:_____ ☐ No

Have you had a **Colonoscopy** in the past 10 years? ☐ Yes: Date _____ Location:_____ ☐ No

If **over 65+ or at risk for Falls**

1. Have you **Fallen** in the past year?
   ☐ No
   ☐ Yes: How many times? _____ Were you Injured? ☐ Yes ☐ No
2. Do you feel unsteady when standing or walking? ☐ Yes ☐ No
3. Do you worry about falling? ☐ Yes ☐ No

Other Preventive Health Care: *Approximate dates, if known.*

Flu Vaccine: _____ Tetanus Vaccine: _____ Cholesterol Blood Test: _____

Pneumonia Vaccine: _____ Shingles Vaccine: _____ Diabetes Screening Test: _____

GENERAL - *You can skip this section if already done at the Front Desk.*

Who is your Emergency Contact person?

Name: _____ Phone: _____

Do you have a Healthcare Representative or Power of Attorney? ☐ No

Name: _____ Phone: _____

Thank you for completing your PRE-visit form!