PROVIDENCE Medical Group Wilsonville

PROVIDENCE MEDICAL GROUP - WILSONVILLE

Welcome to the clinic. Please use this form to help us understand your medical history

Full Name: _____ DOB: _____

Reason for visit today: _____

Recent Medical Providers: _____

PERSONAL HEALTH HISTORY: *Please tell us if you have <u>been diagnosed with</u> any of these conditions. Circle "Y" for yes, "N" for no*

Seasonal Allergies	Y	N	Atrial Fibrillation	Y	N	Kidney Problems	Y	N
Glaucoma	Y	N	Heart Failure	Y	N	Prostate Disease	Y	N
Hearing Loss	Y	N	Heart Valve Disease	Y	N	Sexual Dysfunction	Y	N
Thyroid Problems	Y	N	Bowel Problems	Y	N	Diabetes	Y	N
Asthma	Y	N	Heartburn	Y	N	Bleeding Disorder	Y	N
COPD/Emphysema	Y	N	Hepatitis	Y	N	Stroke	Y	N
Tuberculosis	Y	N	Erectile Dysfunction	Y	N	Mental Health	Y	N
Irregular Heart Beat	Y	N	Infertility	Y	N	Anemia	Y	N
Heart Attack	Y	N	Sexual Infection	Y	N	Eczema/Psoriasis	Y	N
Eating Disorder	Y	N						

Other: _____

Health Screenings (please indicate date of last check):
Colon screening: _____ Bone Density: _____ TB Test: _____
Fasting Labs: _____ HIV test: _____ Hepatitis C: _____ PSA: _____

SURGICAL HISTORY: *Please list any surgeries, hospitalizations, and the approximate date and location:*

Surgery or Reason for Hospitalization	Approximate Date	Location

CURRENT MEDICATIONS: *Please include herbals, supplements, and over the counter medications:*

Medication	Dose	Frequency	Reason for Taking	When Started

<u>Females Only:</u>
Date of Last Menstrual Period: _____ or Menopausal at age _____
Birth Control Method: _____
# of pregnancies: _____ # of deliveries: _____ # of miscarriages: _____ # of abortions: _____
Last Mammogram: _____ Ever had an abnormal mammogram? Yes No If yes, date: _____
Last Pap Smear: _____ Ever had an abnormal Pap? Yes No If yes, date:_____

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ALLERGIES: *Please list all Medication allergies, and the reaction, if known*

Medication	Reaction	Medication	Reaction

FAMILY HEALTH HISTORY: *Please list any known health problems in the following family members:*

	Alive	Age(s)	Deceased	Medical Problems
Mother				
Father				
Sister(s)				
Brother(s)				

SOCIAL HISTORY:

Occupation: _____ **Where were you born and raised?** _____

Marital Status: (circle one) Single Married Divorced Cohabitating

Children? (names, ages): _____ **Others live with you?** _____

Sexual Orientation: (circle your answers): Heterosexual Homosexual Bisexual Transgendered

Habits:

Regular Exercise? Yes ___ No ___ How often? _____ times per week. Type: _____

Do you smoke? _____ If yes, age you started smoking? _____ Year you quit? _____ Packs per day? _____

Are you currently in recovery for alcohol or substance abuse? YES O NO O

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?	O	O
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	O	O

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

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	O	O

REVIEW OF SYSTEMS: *Please circle any of these symptoms you have experienced in the last 3 months:*

Anxiety or Depression	Wheezing	Sexual concerns	Dizziness
Sore throat	Chest Pain	Urinary changes	Weakness
Runny nose	Palpitations	Change in periods	Joint Pains
Hearing loss	Abdominal Pain	Pelvic Pain	Skin rashes
Visual changes	Heartburn	Pain with intercourse	Changing moles
Cough	Bowel habit changes	Headaches	Breast lumps or pain