



HEALTH QUESTIONNAIRE

CASCADE PHYSICIANS, P.C.

19250 S.W. 65TH AVENUE • SUITE 110 • TUALATIN, OREGON 97062
 2222 N.W. LOVEJOY • SUITE 505 • PORTLAND, OREGON 97210
 501 N. GRAHAM • SUITE 100 • PORTLAND, OREGON 97227

Name: _____ Date: _____
Last First Initial

Date of Birth: _____ Age: _____ Occupation: _____

Address: _____
Street City State Zip

Phone #'s: home: _____ work: _____ cell: _____

Name of spouse: _____ Occupation: _____

Nearest relative or Friend: _____
Name Address/Phone

Reason for today's visit: _____

Past History:

HAVE YOU EVER HAD:	yes	no		yes	no		yes	no
Anemia			Kidney Disease			Appendectomy		
Arthritis			Liver Disease			Other Surgery		
Diabetes Mellitus			Thyroid Disease					
Gallbladder Disease			Seizure/Epilepsy					
High Blood Pressure			Stroke					
Heart Disease			Ulcer Disease					

- * Have you ever smoked? _____ If you smoke now, how many cigarettes a day? _____
- * Approx. _____ drinks of alcohol per day.
- * Approx. _____ cups of coffee/ tea per day.
- * Other Drug use? _____

List any medications that you take on a daily basis:

Drug Allergies:

Date of last immunizations: Tetanus _____ Pneumovax _____ Hep A _____ Hep B _____

Family History:

	Age	Living/ Deceased	Health Problems	Age @ death	Cause of death
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Husband/wife	_____	_____	_____	_____	_____

Family History (Continued):

	Age	Living/ Deceased	Health Problems	Age @ death	Cause of death
Son/daughter	___	_____	_____	_____	_____
Son/daughter	___	_____	_____	_____	_____
Son/daughter	___	_____	_____	_____	_____

Women only:

Number of: Pregnancies _____	Last menstrual period _____
Deliveries _____	Age at onset of menstruation _____
Abortions _____	Date of last PAP smear _____ results _____
Miscarriages _____	Form of contraception (if using) _____
	Any problems with contraception _____

Current Health Concerns (circle all recent problems)

- | | | |
|------------------------|----------------------------|---------------------------|
| Abdominal Pain | Fainting Spells | Palpitations |
| Ankle Swelling | Fevers | Painful Urination |
| Anxiety | Frequent Urination | Poor Appetite |
| Bloody/Tarry stools | Headaches | Rash/Itching |
| Breast Concern | Hearing loss/Ringing | Sadness/Change in mood |
| Chest Pain/Discomfort | Heartburn | Sexual Problems |
| Chills | Hot Flash/Night Sweats | Shortness of Breath |
| Constipation | Incontinence | Sneezing/Allergy symptoms |
| Cough | Insomnia/Sleep disturbance | Sudden weakness/numbness |
| Coughing up blood | Joint Pain/Swelling | Tremor |
| Diarrhea | Leg Pain while walking | Vaginal/Penile Irritation |
| Dizziness | Memory Problems | Visual/Eye concerns |
| Easy Bruising/Bleeding | Nausea/Vomiting | Weight loss |
| Excessive thirst | New or changing mole | Wheezing |

Other: _____

Who referred you to our office? _____

Patient signature: _____ **Date:** _____