CASCADE PHYSICIANS, P.C.

NEW PATIENT HEALTH QUESTIONNAIRE - TUALATIN

NAME_____ DATE _____

WHAT WOULD YOU LIKE TO BE CALLED?_____ AGE _____ MARITAL STATUS _____

OCCUPATION _____ WITH WHOM DO YOU LIVE _____

ETHNICITY _____ LANGUAGE _____ RACE_____

REASONS FOR TODAY'S VISIT _____

MEDICAL HISTORY *Circle current or past medical issues, indicating the date of onset*

GLAUCOMA/CATARACTS_____
DECREASED HEARING_____
DIABETES_____
THYROID PROBLEMS_____
HIGH BLOOD PRESSURE_____
HEART DISEASE/ANGINA_____
HIGH CHOLESTEROL_____
STROKE/TIA_____
EMPHYSEMA/COPD_____

ASTHMA/ALLERGIES_____
ULCER/HEART BURN/REFLUX_____
HEPATITIS_____
LIVER PROBLEMS _____
KIDNEY PROBLEMS_____
URINARY PROBLEMS_____
ANEMIA _____
ARTHRITIS_____
FIBROMYALGIA_____
CANCER_____

BROKEN BONES_____
OSTEOPOROSIS_____
SEIZURES_____
WEIGHT ISSUES_____
DEPRESSION/ANXIETY_____
SEXUALLY TRANSMITTED DISEASE_____
HIV/ AIDS_____
PROSTATE PROBLEMS_____
ALCOHOLISM/DRUG USE_____
OTHER_____

DO YOU HAVE ANY SPECIALISTS INVOLVED IN YOUR CARE? IF SO, WHOM (Please List NAME and SPECIALTY)_____
_____

SURGICAL HISTORY *Indicate type and date of surgery*

_____
_____
_____

OTHER HOSPITALIZATIONS *Indicate date and reason for hospitalization* _____

MEDICATIONS ***Include over the counter medications, dose (if known), vitamins & supplements. List on another page, if necessary.***

_____
_____
_____
_____

DRUG ALLERGIES *Indicate type of reaction* _____

PREVENTATIVE CARE:

IMMUNIZATIONS *Indicate date(s) received*
TETANUS/TDAP _____
ZOSTAVAX (SHINGLES) _____
HEPATITIS B _____
GARDASIL (HPV) _____
PNEUMOVAX _____

HISTORY OF POSITIVE PPD (Test for Tuberculosis/ TB)? **YES / NO** WHEN_____
HAVE YOU EVER HAD A COLONOSCOPY? **YES / NO** WHEN AND WHERE_____ WHEN TO FOLLOW UP_____
HAVE YOU EVER HAD A BONE DENSITY SCAN (DEXA)? WHEN AND WHERE_____

WOMEN'S HEALTH *Female Patients, Please Complete*

LAST MAMMOGRAM _____ NORMAL: **YES / NO** LAST PAP TEST _____ NORMAL: **YES / NO**
HISTORY OF ABNORMAL PAP? **YES / NO** WHEN? _____
LAST MENSTRUAL PERIOD_____ **REGULAR / IRREGLUAR** ~OR~ DATE OF MENOPAUSE_____
NUMBER OF PREGNANCIES_____ NUMBER OF BIRTHS_____ NUMBER OF MISCARRIAGES _____

CALCIUM SUPPLEMENT: **YES / NO** AMOUNT_____ VITAMIN D: **YES / NO** AMOUNT_____

PLEASE CONTINUE ON NEXT PAGE.....

PAGE 2 NEW PATIENT HEALTH QUESTIONNAIRE

HEALTH HABITS Circle ALL those apply

TOBACCO USE: **CURRENT** **PREVIOUS** **NEVER** PACKS PER DAY _____ #NUMBER OF YEARS_____ DATE QUIT _____

ALCOHOL USE: **NEVER** **DAILY** **WEEKLY** **OCCASIONAL** AMOUNT_____

AMOUNT OF CAFFINEATED BEVERAGES: #NUMBER DAILY _____

STREET OR INJECTION DRUG USE: **NEVER** **CURRENTLY** **IN PAST** TYPE _____

SEXUAL ACTIVITY: **NOT ACTIVE** **ONE PARTNER** **MULTIPLE PARTNERS** CURRENT BIRTH CONTROL METHOD _____

CURRENT OR PAST SEXUAL PARTNERS: **MEN** **WOMEN** **BOTH**

EXERCISE: **UNABLE** **RARELY** **OCCASIONALLY** **REGULARLY** TYPE_____

FAMILY MEDICAL HISTORY ANY Diabetes, Heart Disease, Stroke, Cancer? Any history of Colon Polyps in Immediate Family?

		LIVING OR DECEASED		YEAR OF BIRTH	MEDICAL ISSUES
MOTHER		L	D	_____	_____
FATHER		L	D	_____	_____
BRO/SIS		L	D	_____	_____
BRO/SIS		L	D	_____	_____
FATHER'S:	MOTHER	L	D	_____	_____
	FATHER	L	D	_____	_____
MOTHER'S:	MOTHER	L	D	_____	_____
	FATHER	L	D	_____	_____

NUMBER OF CHILDREN_____ YEARS OF BIRTH_____ ANY MEDICAL CONDITIONS_____

CURRENT HEALTH CONCERNS Circle ALL recent problems/concerns

UNEXLAINED WEIGHT **LOSS/GAIN**
FEVERS/CHILLS
FATIGUE
SLEEP PROBLEMS/SNORING
POOR APPETITE
HEARING LOSS/RINGING IN EARS
VISUAL/EYE SYMPTOMS: LAST EYE EXAM _____
COUGH
COUGHING UP BLOOD
WHEEZING
CHEST PAIN/DISCOMFORT
PALPATATIONS
ANKLE SWELLING
LEG PAIN WHILE WALKING

EXCESSIVE THIRST
NAUSEA/VOMITING
HEARTBURN
DIARRHEA
CONSTIPATION
ABDOMINAL PAIN
BLOODY/TARRY STOOLS
INCONTINENCE
FREQUENT URINATION
PAINFUL URINATION
VAGINAL/PENILE DISCHARGE
HOT FLASH/NIGHT SWEATS
BREAST CONCERNS
NUMBNESS/TINGLING

JOINT PAIN/SWELLING
NEW OR CHANGING MOLE
SUDDEN WEAKNESS
TREMOR
EASY BRUISING/BLEEDING
RASH/ITCH
HEADACHES
FAINTING SPELLS
DIZZINESS
ANXIETY
SEXUAL PROBLEMS
SADNESS/CHANGE IN MOOD
MEMORY PROBLEMS
ABUSE/RELATIONSHIP ISSUES

OTHER:_____

ANY OTHER ITEMS YOU WISH TO DISCUSS WITH THE DOCTOR:

_____
_____
_____
_____
_____

PREVIOUS HEALTH RECORDS ARE HELPFUL. PLEASE SIGN A RECORD RELEASE ALLOWING US TO REQUEST THESE.

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE