Lake Oswego Health Center
Patient Health History and Policies

Patient's Name: _____
First Middle Last

Excellent healthcare is possible only when the physician completely understands the patient's physical, mental, and emotional conditions. The information you provide helps your practitioner understand your needs and how to help you reach your health goals. ***Please write legibly and answer all questions thoroughly. Please mark anything you may have a question about.***

Address _____
City _____ State _____ Zip code _____

Telephone numbers: Home _____ Work/Cell _____

Patients will be emailed/text/called for appointment reminders via our electronic health records. Please circle preference.

PH (_____) _____-_____ Text ❑YES ❑NO Email (needed for our EHR)_____

SS # _____ Driver's license # _____ Birth Date _____

Age _____ Gender (circle one) M F Other Children _____

Occupation _____ Hours per week _____

Employer _____ Employer address _____

Relationship status ❑Single ❑Married ❑Partnership

Emergency Contact: _____

Relationship: _____ Telephone Number: _____

If someone other than patient is responsible for payment, please complete the following:
Name of responsible party _____ SS# _____

Relationship to patient _____ Phone # _____

Employer & address _____
_____

Please provide your insurance ID# _____ Group # _____
Name of insurance _____
Customer service number _____
Secondary insurance information _____
Policy holder and DOB if different than pt _____

I acknowledge that I am financially responsible for all charges If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable arbitration and / or attorney fees. I hereby authorize Lake Oswego Health Center, PC to release information necessary to secure payment.

Signature: _____ **Date:** _____

Are you currently receiving health care? ❑Y ❑N
If yes, please list your current providers _____)_____
If no, when and where did you last receive medical care? _____

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, dust)? If yes, please list allergen and reaction _____

How did you hear about our clinic? _____

May we thank the person who referred you? _____

SELF & FAMILY HISTORY

Please list past hospitalizations or surgeries _____
_____

Please list any recent lab work with any abnormal results _____

What diagnostic imaging studies have you had?

		❑ Bone density scan	❑ Mammogram
❑ Electrocardiogram	❑ Electroencephalogram	❑ X-rays	❑ CT scan
❑ Ultrasound	❑ Colonoscopy/Sigmoidoscopy	❑ MRI	❑ Other

Medications and/or Supplements

Do you take or use any of the following?

❑ Pain relievers (aspirin, ibuprofen)	❑ Sleeping Pills	❑ Tranquilizers
❑ Diet pills, appetite suppressants	❑ Antibiotics	❑ Laxatives
❑ Cortisone (cream or pills)	❑ Thyroid medication	❑ Antacids

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking with dosages and brand names, if possible: (Please add how long you have been on this med)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

General

Height _____ Weight _____lbs Weight one year ago _____lbs
Maximum weight _____Lbs When? _____ Are you happy with your current Wt? ❑Y ❑N
Energy Level

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

At what time of day is your energy the best? _____ Worst? _____

Is there any condition (physical, mental, emotional) from which you feel that you have not fully recovered?

Family History Please note which relative and age of onset if known. Example P-Gpa 50 (paternal grandfather at 50). Please include 1st and 2nd degree relatives only.

Do you have a family history of any of the following (please circle)?

Alcoholism/addiction	Cataracts	Goiter	Mental Illness
Allergies	Celiac	Hayfever/hives	Skin conditions
Anemia	Depression	Headaches/Migraines	Stroke
Arthritis	Diabetes	Heart Disease	Suicide
Asthma	Liver Disease	Heart Murmur	Thyroid Problems
Autoimmune	Epilepsy	High Blood Pressure	Tuberculosis
Cancer, type?	Gall Bladder Disease	Kidney Disease	Other _____

Is your father living? Yes; his age ____ No; age at time of death _____ Cause of death _____
Is your mother living? Yes; her age ____ No: age at time of death _____ Cause of death _____
Do you have siblings? If so, how is their health? _____

Childhood Illnesses

Any major health concerns (i.e. Polio, Rhuematic Fever, etc.) _____

Past Immunizations

Please circle any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diptheria	Polio	Measles/Mumps/Rubella (MMR)
Pertussis	Tetanus	Other _____

REVIEW OF SYSTEMS (self)

Please circle. Y= Yes, present condition P=Problem in the past N=No, never had the condition

Head		Head injury	Y P N	Jaw/TMJ Problems	Y P N
Headaches	Y P N	Migraines	Y P N		
Ears					
Ringing	Y P N	Excess Wax	Y P N	Impaired Hearing	Y P N
Earaches	Y P N				
Neck					
Lumps	Y P N	Swollen Glands	Y P N	Pain or Stiffness	Y P N
Goiter	Y P N				
Skin					
Rashes	Y P N	Psoriasis	Y P N	Eczema, Hives	Y P N
Lumps	Y P N	Acne, Boils	Y P N	Color Changes	Y P N
Itching	Y P N	Loss of Hair	Y P N	Night Sweats	Y P N
Musculoskeletal					
Joint swelling	Y P N	Muscle Spasms	Y P N	Weakness	Y P N
Arthritis	Y P N	Broken Bones	Y P N	Sciatica	Y P N
Osteoporosis	Y P N	Muscle Pain	Y P N	Joint pain/stiffness	Y P N
Eyes		Recent Vision Changes	Y P N	Last Eye Exam Date _____	
Blurred Vision	Y P N	Cataracts	Y P N	Glasses/Contacts	Y P N
Glaucoma	Y P N	Tearing/Dryness	Y P N	Eye Pain/Strain	Y P N
Spots in Eyes	Y P N	Color Blind	Y P N	Double Vision	Y P N
Nose/Sinuses					
Stuffiness	Y P N	Loss of Smell	Y P N	Sinus Problems	Y P N
Hayfever	Y P N	Nose Bleeds	Y P N	Frequent Colds	Y P N

Mouth/Throat		Root Canals	Y N	Wisdom Teeth	Y N
Hoarseness	Y P N	Gum Problems	Y P N	Freq. Sore Throat	Y P N
Jaw Clicks	Y P N	Dental Cavities	Y P N	Sore Lips/Tongue	Y P N
Grind Teeth	Y P N	Dry Mouth/sores	Y P N	Change in Thirst	Y P N
Respiratory		Shortness of Breath	Y P N	Asthma/wheezing	Y P N
Tuberculosis	Y P N	Spitting up Blood	Y P N	Emphysema	Y P N
Cough	Y P N	Bronchitis	Y P N	Pneumonia	Y P N
Cardiovascular		Deep Leg Pain	Y P N	Poor Circulation	Y P N
Chest Pain	Y P N	Blood Clots	Y P N	Varicose Veins	Y P N
Murmur	Y P N	Rheumatic Fever	Y P N	Easy Bruising	Y P N
Ankle Swelling	Y P N	Valve Problems	Y P N	Palpitations	Y P N
High Cholesterol	Y P N	High/Low Blood Pressure	Y P N		

Gastrointestinal

Diarrhea	Y P N	Constipation	Y P N	Changes in Appetite	Y P N
Ulcers	Y P N	Black Stool	Y P N	Liver Disease	Y P N
Jaundice	Y P N	Hemorrhoids	Y P N	Gall Bladder Disease	Y P N
Heartburn	Y P N	Abdominal Pain	Y P N	Blood in Stool	Y P N
Trouble Swallowing	Y P N	Belching	Y P N	Passing Gas	Y P N

How many bowel movements per day? _____

Urinary

Incontinence	Y P N	Frequent Infections	Y P N	Painful Urination	Y P N
Kidney stones	Y P N	Frequency	Y P N	Urgency	Y P N

Wake to urinate? If so, how often _____

Blood/Peripheral Vascular

Anemia	Y P N	Cold Hands/Feet	Y P N	Thrombophlebitis	Y P N
Leg Pain	Y P N	Easy Bruising	Y P N	Varicose Veins	Y P N

Neurological		Loss of Memory	Y P N	Seizures	Y P N
Fainting	Y P N	Paralysis	Y P N	Numbness/Tingling	Y P N

Mental/Emotional		Substance Abuse	Y P N	Nervousness	Y P N
Mood Swings	Y P N	Easting Disorder	Y P N	Tension/Stressed	Y P N
Anxiety	Y P N	Depression	Y P N	Thoughts of Suicide	Y P N

Endocrine

Hypothyroid	Y P N	Excessive Thirst	Y P N	Cold Intolerance	Y P N
Hyperthyroid	Y P N	Excessive Hunger	Y P N	Heat Intolerance	Y P N

Reproductive		Hernias	Y P N	Sexual Difficulty	Y P N
Sex with	M F	Discharge or Sores	Y P N	Sexually active?	Y P N

Infection (i.e. herpes, etc) Y P N Date of last STD/STI testing? _____

Type of birth control (if applicable) _____

MALE Reproductive

Testicular Masses	Y P N	Prostate Issues	Y P N	Testicular Pain	Y P N
Impotence	Y P N	Premature Ejaculation	Y P N	Date of last physical exam?	_____

FEMALE Reproductive

Age of first menses _____ Age of last menses (if menopausal) _____

Length of cycle _____ Duration of menses _____

Any gynecological procedures (i.e. hysterectomy full or partial, LEEP, colposcopy, ablation, etc)

_____

Date of last annual exam? _____ Any previous abnormal paps? ❑Y ❑N

Painful menses	Y P N	Endometriosis	Y P N	Ovarian cysts	Y P N
Heavy flow	Y P N	Fertility issues	Y P N	Cervical dysplasia	Y P N
Breasts tender	Y P N	PMS	Y P N	Bleeding between cycles	Y P N
Fibroid/polyps	Y P N	Cycles regular	Y P N	Menopausal symptoms	Y P N
Hormones	Y P N	Breast lump(s)	Y P N	Trouble Conceiving	Y P N
Nipple discharge	Y P N	Do self breast exams	Y P N	Fibrocystic breast	Y P N

# of pregnancies _____ # of live births_____ # of miscarriages _____ # of terminations_____

Is there anything else you would like us know in order to serve you better?

_____

_____

Do you have any physical limitations? _____

List your top 3 goals for today?

_____

_____

What are you **not** doing because of your current health complaints?

_____

Habits

Please write what you last had for breakfast, lunch, dinner, and snacks **in the last 24 hours**

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Fluids _____

Do you have any dietary restrictions and why? _____

Please indicate the following

Smoke ❑Y ❑P ❑N If yes, amount_____

Alcohol ❑Y ❑N If yes, amount _____

Caffeine (soda, coffee, tea, etc…) ❑Y ❑N If yes, amount_____

TV Hours per day ❑ 0-1 ❑ 1-3 ❑ 3-4 ❑ 4 +

Exercise ❑Y ❑N If yes, amount and type_____

Any injuries that keep you from exercising more? _____

Main Interests/Hobbies _____

Do you have a spiritual practice: ❑Y ❑N

How many hours do you sleep? _____ Do you wake rested? ❑Y ❑N

Do you have any stress management practices? ❑Y ❑N

What do you do to relax? _____

Do you have a good support system (friends, family)? _____

Exposed to chemicals/tobacco at home or at work? ❑Y ❑P ❑N If yes, list: _____
_____

Any toxic exposure known?_____

How motivated are you to make changes in your life to improve your health (10=most)?

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What changes are you willing to make to improve your health?

❑Lifestyle Changes ❑Take Supplements ❑Exercise ❑Nutrition changes
❑Smoking Cessation ❑Sleep Patterns ❑Counseling ❑Alcohol reduction/cessation
❑Recreational Hours/Hobbies