

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?
 Electrocardiogram Electroencephalogram Bone density scan Mammogram
 Ultrasound Colonoscopy/Sigmoidoscopy X-rays CT scan
 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.

Diphtheria	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

Headaches	Y P N	Head injury	Y P N	Jaw/TMJ Problems	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

Blurred Vision	Y P N	Recent Vision Changes	Y P N	Last Eye Exam Date	_____
Glaucoma	Y P N	Cataracts	Y P N	Glasses/Contacts	Y P N
Spots in Eyes	Y P N	Tearing/Dryness	Y P N	Eye Pain/Strain	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

<u>Mouth/Throat</u>		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

<u>Respiratory</u>		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

<u>Cardiovascular</u>		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		

<u>Gastrointestinal</u>		Constipation	Y P N	Changes in Appetite	Y P N
Diarrhea	Y P N	Black Stool	Y P N	Liver Disease	Y P N
Ulcers	Y P N	Hemorrhoids	Y P N	Gall Bladder Disease	Y P N
Jaundice	Y P N	Abdominal Pain	Y P N	Blood in Stool	Y P N
Heartburn	Y P N	Belching	Y P N	Passing Gas	Y P N
Trouble Swallowing	Y P N				
How many bowel movements per day? _____					

<u>Urinary</u>		Frequent Infections	Y P N	Painful Urination	Y P N
Incontinence	Y P N	Frequency	Y P N	Urgency	Y P N
Kidney stones	Y P N				
Wake to urinate? If so, how often _____					

<u>Blood/Peripheral Vascular</u>		Cold Hands/Feet	Y P N	Thrombophlebitis	Y P N
Anemia	Y P N	Easy Bruising	Y P N	Varicose Veins	Y P N
Leg Pain	Y P N				

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

<u>Mental/Emotional</u>		Substance Abuse	Y P N	Nervousness	Y P N
Mood Swings	Y P N	Eating Disorder	Y P N	Tension/Stressed	Y P N
Anxiety	Y P N	Depression	Y P N	Thoughts of Suicide	Y P N

<u>Endocrine</u>		Excessive Thirst	Y P N	Cold Intolerance	Y P N
Hypothyroid	Y P N	Excessive Hunger	Y P N	Heat Intolerance	Y P N
Hyperthyroid	Y P N				

<u>Reproductive</u>		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) _____					

<u>MALE Reproductive</u>		Prostate Issues	Y P N	Testicular Pain	Y P N
Testicular Masses	Y P N	Premature Ejaculation	Y P N	Date of last physical exam?	_____
Impotence	Y P N				

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