Tualatin Internal Medicine

Patient Questionnaire

Last Name:	**First Name:**	**DOB:**
Sex: ☐**M** ☐**F**	**Gender:** ☐**M** ☐**F** ☐**Other**	**Occupation:**
☐ **Single** ☐ **Partnered** ☐**Married** ☐ **Separated** ☐ **Divorced** ☐**Widowed**		
Previous Doctor:	**Date of last Physical Exam:**	

PERSONAL HEALTH HISTORY			
Immunizations	☐Tetanus	☐ Pneumonia/Pneumovax	☐ Hepatitis A
	☐Influenza (Flu)	☐ Prevnar 13	☐ Hepatitis B
	☐Gardasil (HPV)	☐ Shingles Vaccine/Zostavax	

Past or Present Medical History: (check all that apply to you)			
☐Alcohol/Drug problem	☐Emphysema/COPD	☐Liver Disease	☐Blood Clots
☐Anxiety	☐Heart-Coronary Artery Dis.	☐Prostate problem	☐ Neuropathy
☐Arthritis	☐Heart-Heart Failure/CHF	☐Psychiatric- Depression	☐Sleep Apnea
☐Asthma	☐High Blood Pressure	☐Psychiatric Disorder- Other	☐ Heart Murmur
☐Atrial Fibrillation	☐High Cholesterol	☐Seizure Disorder	☐Migraines
☐Dementia	☐Hypothyroidism (low)	☐Stroke	☐Hepatitis
☐Diabetes	☐Hyperthyroidism (high)	☐Ulcers of the Stomach	☐Diverticulosis
☐Cancer	☐Kidney Disease	☐STD/sexual infection	☐ Colon Polyps
Type: _____		☐Abnormal Pap Test	☐ Positive TB test
		☐Peripheral Artery Disease	

Surgeries (include year or age at time of surgery)		
☐Appendectomy	☐Tonsillectomy	☐C-Section (Cesarean)
☐Cardiac Bypass (CABG)	☐Hernia Repair	☐Hysterectomy-Partial
☐Cardiac Angioplasty/Stent	☐Prostate Surgery	☐Hysterectomy-Total
☐Gallbladder Laparoscopic	☐Vasectomy	☐Tubal Ligation
☐Gallbladder Open	☐Cataract Surgery: ☐Left ☐Right	☐Breast Surgery: ☐Left ☐Right
Orthopedic (type):		
Other Surgery:		

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Screening Tests	Approx Date:			Approx Date:	
Cholesterol Test		☐Normal ☐Abnormal	Pap Smear		☐Normal ☐Abnormal
Colonoscopy		☐Normal ☐Abnormal	Mammogram		☐Normal ☐Abnormal
Prostate Test		☐Normal ☐Abnormal	Bone Density Test		☐Normal ☐Abnormal
Dental Exam		☐Normal ☐Abnormal			☐Normal ☐Abnormal
Eye Exam		☐Normal ☐Abnormal ☐Glasses ☐Contacts ☐Cataracts			

Medications: List prescribed and over-the-counter medications	
Drug Name:	Dose & Directions:

Allergies/Reactions to Medications:	
Drug Name:	Reaction/Comments:
Food/Environmental Allergies:	
Drug Name:	Reaction/Comments:

Last Name:_____ First Name:_____ DOB:_____

SEXUAL HEALTH		
☐Sexually active ☐Not currently sexually active ☐Never sexually active		# partners in past year:
History of Sexually Transmitted Infection? ☐No ☐Yes Type/date:		
Current contraception method:		
# of children:	**WOMEN**: # of pregnancies:	# of miscarriages:

HEALTH HABITS AND PERSONAL SAFETY	
Exercise	☐Sedentary (No exercise) ☐Mild exercise (i.e., climb stairs, walk 3 blocks, golf) ☐Occasional vigorous exercise (i.e., work or recreation, 1-3x/week for 30 min.) ☐Regular vigorous exercise (i.e., work or recreation >3x/week for 30 min.)

Tobacco	**Cigarette use**: ☐Never ☐Former smoker: Quit date or age: ☐Current smoker: # packs/day: # years: Other tobacco use: ☐Pipe ☐Cigars ☐Chewing tobacco ☐Vape

Alcohol	Do you drink alcohol? ☐No ☐Yes: ☐0-1 time/month ☐2-4 times/month ☐every week Each week, how many: Servings of beer? ____ Glasses of wine? _____ Shots/mixed drinks?_____ When did you last have more than 4 drinks in one day? _____

Drugs	Have you used recreational or street drugs within the last 2 years? ☐No ☐Yes Have you ever used recreational drugs with a needle? ☐No ☐Yes Types of drugs used: *check all that apply:* ☐Marijuana ☐Methamphetamines ☐Cocaine ☐Heroin ☐Other:_____

Last Name:_____ First Name:_____ DOB:_____

FAMILY HEATH HISTORY			
Family Member		Age	Medical Conditions (indicate Healthy or: diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer & type)
Mother	☐ Living ☐ Deceased		
Father	☐ Living ☐ Deceased		
Grandmother *Mother's Side*	☐ Living ☐ Deceased		
Grandfather *Mother's Side*	☐ Living ☐ Deceased		
Grandmother *Father's Side*	☐ Living ☐ Deceased		
Grandfather *Father's Side*	☐ Living ☐ Deceased		
Sibling ☐M ☐F	☐ Living ☐ Deceased		
Sibling ☐M ☐F	☐ Living ☐ Deceased		
Sibling ☐M ☐F	☐ Living ☐ Deceased		
Sibling ☐M ☐F	☐ Living ☐ Deceased		
Sibling ☐M ☐F	☐ Living ☐ Deceased		
	☐ Living ☐ Deceased		
	☐ Living ☐ Deceased		

Last Name:_____ First Name:_____ DOB:_____

Check if you are currently experiencing any of the following:

GENERAL:

	Fatigue
	Fever
	Weight gain > 10lbs
	Weight loss >10lbs

SKIN:

	Rash
	New/Changing skin lesions
	Nail changes
	Hair loss

EYES/EARS/NOSE/THROAT:

	Vision changes
	Decreased hearing
	Ear pain
	Ringing in ears
	Nasal congestion
	Nose bleeds
	Hoarse voice
	Sore throat
	Sneezing
	Sinus problems
	Lump in neck

RESPIRATORY:

	Wheezing
	Difficulty breathing
	Night sweats
	Bloody sputum
	Productive cough
	Dry cough
	Shortness of breath

MUSCULOSKELETAL:

	Joint pain
	Joint swelling
	Joint stiffness
	Muscle pain
	Muscle weakness

CARDIOVASCULAR:

	Chest pain
	Racing heart
	Irregular heartbeat
	Shortness of breath
	Leg pain with walking
	Ankle or Leg swelling
	Decreased exercise tolerance
	Awakening at night due to trouble breathing

GASTROINTESTINAL:

	Abdominal pain
	Change in bowel habits
	Constipation
	Diarrhea
	Nausea
	Vomiting
	Trouble swallowing
	Heartburn
	Acid reflux
	Rectal bleeding

HEMATOLOGIC:

	Easy bruising
	Prolonged bleeding
	Enlarged lymph nodes

NEUROLOGIC:

	Headaches
	Dizziness/vertigo
	Numbness/tingling
	Passing out
	Difficulty walking
	Seizures
	Tremor
	Frequent falls

PSYCHIATRIC:

	Depression
	Anxiety
	Hallucinations
	Mood swings
	Suicidal thoughts
	Insomnia/sleep problems
	Psychiatric treatment

ENDOCRINE:

	Change in appetite
	Cold or heat intolerance
	Increased thirst
	Changes in sex drive
	Hair loss or excess growth

ALLERGIC/IMMUNOLOGICAL:

	Allergy/Hayfever symptoms
	Itching
	Frequent infections
	Exposure to infection

BREAST:

	Breast lumps/mass
	Breast pain
	Nipple discharge
	Rash on breast

GENITOURINARY:

	Painful urination
	Frequent urination
	Blood in urine
	Loss of bladder control
	Difficulty passing urine
	Hernia

MEN:

	Difficulty starting stream
	Change in urine stream
	Penile discharge
	Testicular pain or mass
	Hernia

WOMEN:

	Pelvic pain
	Irregular periods
	Vaginal discharge
	Excessive vaginal bleeding
	Bleeding after menopause
	Vaginal dryness
	Hot flashes
	Pain with intercourse

Reviewed by/Date: _____

Name _____ Birthdate_____ Doctor _____ Today's Date _____

A Survey from Your Healthcare Provider

Part of routine screening for your health includes reviewing mood and emotional concerns.

During the past two weeks, have you often been bothered by of the following problems?

Feeling down, depressed, irritable or hopeless? ❒ Yes ❒ No

Little interest or pleasure in doing things? ❒ Yes ❒ No

If you answered "Yes" to either question above, please answer all questions below.

During the past two weeks, how often have you been bothered by the following problems?	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
Feeling down, depressed, irritable or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss, or overeating				
Feeling tired or having little energy				
Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, like reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

For Office Use Only: Total Score