



Office: 503.885.7770

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IMPORTANT: Please fill in as completely as possible.

Name _____ Social Security # _____ Date of Birth _____

PATIENT MEDICAL INFORMATION

DO YOU TAKE ANY MEDICATIONS? Yes No If yes, please list: _____

BLOOD THINNERS? Yes No

ARE YOU ALLERGIC TO ANY DRUGS? No Yes If yes, please list: _____

When was your last tetanus shot? ____/____/____

What is your current weight? _____ height? _____

PAST MEDICAL HISTORY

Have you had any surgeries? Yes No

Please list: _____

Have you had any injuries? Yes No

Please list: _____

Please list any past or present illnesses:

REVIEW OF SYMPTOMS

Do you currently experience:

- | | | | |
|----------------------|--|--------------------------------------|--|
| Night sweats | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Gain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rashes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stiffness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Numbness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood in stool | <input type="checkbox"/> Yes <input type="checkbox"/> No | ringing in ears | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Muscle pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Irregular heart rate | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive thirst | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fever and chills | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive hunger | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive need to go to the bathroom | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Weakness | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

SOCIAL HISTORY

Do you smoke? Yes No How many packs per day? _____

Are you married? Yes No How many children? _____ Ages: _____

What are your hobbies: _____

FAMILY HISTORY

Do you or family members have:

- | | | | |
|---------------|--|----------------------------|--|
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bad reaction to Anesthesia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Diseases: | _____ |