New Patient Health Questionnaire

What is your health concern at this time and what is the reason for your visit?

____
____

List all prescription and non-prescription medications you take.
Patients with Diabetes: List the glucometer brand, test strip brand, and how many times you check your blood sugar in a day, if you use a pen or vial.
If you do not take any medications, write none.

****FOR PRESCRIPTION REFILLS CALL YOUR PHARMACY FIRST****

Medication: Strength: Dose:

____
____
____
____
____
____

****FOR PRESCRIPTION REFILLS CALL YOUR PHARMACY FIRST****

Pharmacy with location: ____

Are you allergic to any medications: YES NO
If yes, name drugs and describe reaction: ____________________________
____
____

Medical History: List **all** past **surgeries**, **hospitalizations** and **illnesses.**
If none, write none.

Problem: Date: Problem: Date:

____
____
____
____
____
____
____
____
____

If applicable, date of last:
DEXA____________________ Mammogram____________________ Colonoscopy________________

Health Maintenance:
Have you received your annual flu vaccination? YES NO
Date of last tetanus vaccination: ______________ ______
Date of last Pneumovax (pneumonia) vaccination, if applicable: ____________________

Patient Name ____ DOB ____________________

Family Health

If there are no health problems, write none for which it applies to the family member. If health problem is not known for specific family member, write unknown. Under other family members list whether family member is **maternal or paternal. Names are not needed.**

List all health problems of your **blood-related family members**, along with age and cause of death. Specifically mention a history of diabetes, cancer (type), heart disease including strokes, lung disease, thyroid disease, depression or alcoholism.

Father: □ living □ deceased. Age: ______________
Medical Condition: ____
____

Mother: □ living □ deceased. Age: ______________
Medical Condition: ____
____

Sister(s): □ living □ deceased. Age(s): ____________
Medical Condition: ____
____

Brother(s): □ living □ deceased. Age(s): ___________
Medical Condition: ____
____

Son(s): □ living □ deceased. Age(s): ____________
Medical Condition: ____
____

Daughter(s): □ living □ deceased. Age(s): ____________
Medical Condition: ____
____

Other family member(s) Maternal or Paternal: □ living □ deceased. Age(s): __________
Medical Condition: ____
____

Other family member(s) Maternal or Paternal: □ living □ deceased. Age(s): __________
Medical Condition: ____
____

Patient Name ____ DOB ____________________

Social History

Usual Occupation (work done most of life):______________________________

Marital Status: Married Divorced Separated Widowed Single

Race ________________ Ethnicity ________________ Language ____________

Who lives in your household (name, relationship, age):______________________________

____

Children: YES NO Number of sons: ________ Number of daughters: __________

Use of Tobacco: YES NO FORMER SECOND-HAND
Type (circle): Chewing Cigar Cigarettes Pipe Other:________
Amount (can/pack) per day/week/month: ______ Number of years: ______ Year Quit: ______

Use of Alcohol: YES NO FORMER
Type (circle): Beer Wine Liquor Hard Liquor Methanol Other: ________
Amount (glass/bottle/can) per day/week/month: ______Year quit: _____

Use of Caffeine: YES NO
Type (circle): Coffee Soda Tea Tablets Energy drinks Chocolate Other: ________
Amount (can/oz/cup) per day/week/month: ____________

Do you exercise regularly? YES NO
If yes, what exercises? ____
How many days per week? ________________ How many hours per week? ______________

Animals in the home: YES NO Circle: Dog Cat Bird Other (please specify):____________

Circle the items found in your home:
FIREARMS SMOKE DETECTOR FIRE EXTINGUISHERS CARBON-MONOXIDE DETECTOR

Do you use seatbelts? YES NO

Optional to answer: Do you have a religious affiliation? ____________ Religion: ____________
Would you like spiritual information for combating stress, depression, drug abuse or other problems? YES NO

Patient Name ______________________________ DOB ______________

Review of Systems
Circle New or Recent Changes and Explain

1. Chills, fever, or night sweats? ______________________
2. Recent change in weight? ______________________
3. Change in vision, smell or hearing loss? ______________________
4. Nasal congestion or drainage? ______________________
5. Voice change, difficulty swallowing or hoarseness? ______________________
6. Shortness of breath, cough or wheezing? ______________________
7. Exposure to tuberculosis? ______________________
8. Chest pain, swelling in the feet or ankles, irregular heart beat? ______________________
9. Numbness, tingling, pain or varicose veins in the lower extremities? ______________________
10. Constipation, diarrhea, or blood in the stool? ______________________
11. Nausea, vomiting, reflux or heartburn? ______________________
12. Pain with urination, frequent urination or waking during the night to urinate, blood in the urine, urgency or urinary incontinence? ______________________
13. Headaches, dizziness, light-headedness, tremors, difficulty walking or recent loss of consciousness? ______________________
14. Difficulty concentrating, difficulty sleeping, or frequent snoring? ______________________
15. Changes in skin, rashes or acne, or nail changes? ______________________
16. Food allergies, bee sting allergies, asthma or hay fever? ______________________
17. Any sexual problems you wish to discuss? ______________________
18. Any extra hair growth or unusual hair loss? ______________________
19. Muscle, back, bone or joint pain? ______________________
20. Swollen lymph nodes, easy bleeding or bruising? ______________________

Women only:

1. Date of last menstrual cycle: ______________________
2. Menstrual cycles: Regular or Irregular? ______________________
3. Do you perform regular breast self-exams? ______________________
4. Current form of birth control, if applicable: ______________________
5. Any breast discharge or lumps? ______________________
6. Have you ever used any type of hormone replacement? ______________________

Patient Name ______________________ DOB ______________

Medical Information Release Form

Name: ________________________________ Date of Birth: ______________

Release of Information

[ ] Please list family or friends we have your permission to speak with regarding your medical condition and care. **Please include name and phone number.**

[ ] Spouse____

[ ] Child(ren) ____

[ ] Other____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number: ____________________
If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

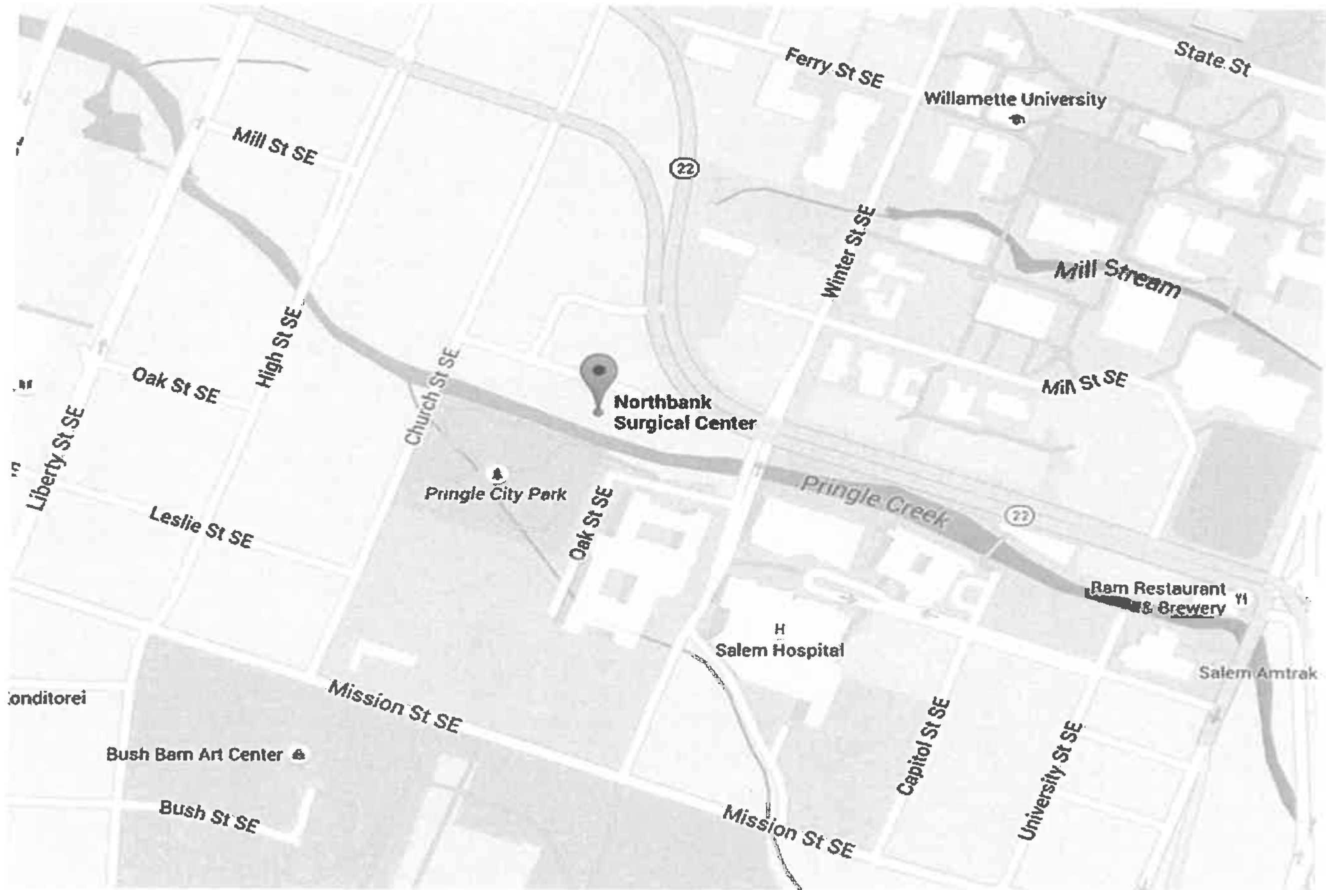
Signature: ________________________________ **Date:** __________

Print Name: ________________________________

Patient Name ______________________________ DOB ______________

Willamette Valley Endocrinology

700 Bellevue St. S.E., Suite 240, Salem, OR 97301



Heading South on I-5.

- Take **Exit 253 to Hwy 22/99E/Mission St SE** and turn **right**.
- Continue on **Mission St** to **Church St SE.**
- Turn right on **Church St SE.**
- Continue on **Church St** to first **right** at **Bellevue St SE** and turn **right.**
- Go down to end of cul-de-sac to **Northbank Plaza.**

Heading North on I-5.

- Take **Exit 253 to Hwy 22/99E/Mission St SE** and turn **left.**
- Continue on **Mission St** to **Church St SE.**
- Turn right on **Church St SE.**
- Continue on **Church St** to first **right** at **Bellevue St SE** and turn **right.**
- Go down to end of cul-de-sac to **Northbank Plaza.**

From West Salem - Wallace Road

- Merge onto **OR-22 E/Center St Bridge** via the ramp to **Salem.**
- Merge onto **OR-22 E/OR-99E BUS S/Front St NE** via the ramp to **Albany.**
- Turn **left** at **Trade St SE.**
- Turn **right** at **Church St SE.**
- Take the 1st **left** onto **Bellevue St SE**