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Health History Questionnaire

Patient's Name: _____
(Last) (Middle) (First)




Medicine is possible only when the physician completely understands the patient's physical, mental, and emotional condition. The information you provide helps the doctor understand your needs and how to help you reach your health goals. Please answer each question completely. Print all information and mark anything you have a question about.

Address: _____
Street City State Zip

Phone: _____ Date of Birth: _____ Age: _____
Home Work

Gender: M F SSN: _____ Occupation: _____ Marital Status: _____

Emergency Contact: _____
Name Phone Relationship

How did you hear about us? _____    Email: _____

What are your most important health concerns? _____

<p>HOSPITALIZATION AND SURGERY</p> <p>What hospitalizations or surgeries have you had? _____ _____ _____ _____</p>	<p>X-RAYS AND SPECIAL</p> <p>What diagnostic imaging studies have you had? (Please circle all that apply). Electrocardiogram X-rays CT Scan Mammogram MRI Bone Density Scan Other _____</p>
<p>MEDICATIONS OR SUPPLEMENTS</p> <p>List medications or supplements that you currently take. _____ _____ _____</p>	<p>ALLERGIES</p> <p>Do you have allergies to food, drugs, or allergens in your environment (cats, mold, dust)? If yes please explain. _____ _____ _____</p>
<p>IMMUNIZATIONS</p> <p>Have you had any of the following immunizations have</p>	


Childhood diseases (Circle all that apply) Measles Diphtheria Mumps Rubella Polio Pertussis Tetanus shot Other _____	Have you had any of the following? (Circle all that apply) Scarlet fever Diphtheria Rheumatic Fever Mumps Measles German Measles Other_____
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SELF AND FAMILY HISTORY

Please list any disease that you or any family member currently has or has had in their life. Family members include parents, siblings, grandparents, aunts, uncles, and children. Please list all illnesses such as cancer, diabetes, heart disease, stroke, liver disease, kidney disease, asthma, mental illness, high blood pressure, etc.

REVIEW OF SYSTEMS

<u>GENERAL</u> Weight _____ Weight 1 year ago _____ Maximum Weight _____ When _____ Height _____ (Place a check next to all that apply.) <u>SKIN</u> <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema, hives <input type="checkbox"/> Acne, boils <input type="checkbox"/> Itching <input type="checkbox"/> Color change <input type="checkbox"/> Lumps <input type="checkbox"/> Night sweats <u>HEAD</u> <input type="checkbox"/> Headache <input type="checkbox"/> Head Injury <u>EYES</u> <input type="checkbox"/> Impaired vision <input type="checkbox"/> Glasses or contacts <input type="checkbox"/> Eye Pain <input type="checkbox"/> Tearing or dryness <input type="checkbox"/> Double vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <u>EARS</u> <input type="checkbox"/> Impaired hearing <input type="checkbox"/> Ringing <input type="checkbox"/> Earache <input type="checkbox"/> Dizziness	<input type="checkbox"/> Stuffiness <input type="checkbox"/> Hay fever <input type="checkbox"/> Sinus problems <u>MOUTH AND SINSUES</u> <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Sore tongue <input type="checkbox"/> Gum problems <input type="checkbox"/> Hoarseness <input type="checkbox"/> Dental cavities <u>NECK</u> <input type="checkbox"/> Lumps <input type="checkbox"/> Swollen glands <input type="checkbox"/> Goiter <input type="checkbox"/> Pain or stiffness <u>RESPIRATORY</u> <input type="checkbox"/> Cough <input type="checkbox"/> Sputum <input type="checkbox"/> Spiting up blood <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pleurisy <input type="checkbox"/> Emphysema <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Pain on breathing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Tuberculosis <u>CARDIOVASCULAR</u>	<input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Chest pain <input type="checkbox"/> Swelling in ankles <input type="checkbox"/> Palpitations <u>GASTROINTESTINAL</u> <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Change in thirst <input type="checkbox"/> Change in appetite <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood Bowel movements How often? _____ Is this a change? Yes No <input type="checkbox"/> Blood in stool <input type="checkbox"/> Belching or passing gas <input type="checkbox"/> Jaundice (yellow skin) <input type="checkbox"/> Liver disease <input type="checkbox"/> Hemorrhoids <u>URINARY</u> <input type="checkbox"/> Pain on urination <input type="checkbox"/> Increased frequency <input type="checkbox"/> Frequency at night <input type="checkbox"/> Inability to hold urine <input type="checkbox"/> Frequent infections <input type="checkbox"/> Kidney stones <u>FEMALE REPRODUCTIVE</u> Age menses began? _____ Average number of days? _____
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<p><u>NOSE AND SINUSES</u></p> <p><input type="checkbox"/> Frequent colds</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Pain during intercourse</p> <p><input type="checkbox"/> Painful menses</p> <p><input type="checkbox"/> Excessive flow</p> <p>Birth control? Y N</p> <p>What type? _____</p> <p>Number of pregnancies _____</p> <p>Number of live births _____</p> <p>Number of miscarriages _____</p> <p>Number of abortions _____</p> <p>Difficult conceiving? Y N</p> <p>Menopausal symptoms? Y N</p> <p>Are you sexually active? Y N</p> <p>Sexual difficulties Y N</p> <p>Venereal disease Y N</p> <p>Do you do self-exams? Y N</p> <p><input type="checkbox"/> Lumps</p> <p><input type="checkbox"/> Pain or tenderness</p> <p><input type="checkbox"/> Nipple discharge</p>	<p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Angina</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Murmurs</p> <p><input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> Numbness or tingling</p> <p><input type="checkbox"/> Loss of memory</p> <p><u>ENDOCRINE</u></p> <p><input type="checkbox"/> Hypothyroid</p> <p><input type="checkbox"/> Heat or cold intolerance</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Excessive hunger</p> <p><u>BLOOD</u></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Easy bleeding or bruising</p> <p><u>EMOTIONAL</u></p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Mood swings</p> <p><input type="checkbox"/> Anxiety or nervousness</p> <p><input type="checkbox"/> Tension</p>	<p>Length of cycle? _____</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Are cycles regular</p> <p>Eat three meals daily? Y N</p> <p>Read? Y N</p> <p>How many hours per day? _____</p> <p>Use recreational drugs? Y N</p> <p>Use tobacco? Y N</p> <p>Use alcoholic beverages? Y N</p> <p>Have you been treated for alcoholism? Y N</p> <p>Have you been treated for drug dependence? Y N</p>
<p><u>MALE REPRODUCTIVE</u></p> <p><input type="checkbox"/> Hernias</p> <p><input type="checkbox"/> Testicular masses</p> <p><input type="checkbox"/> Testicular pain</p> <p>Are you sexually active? Y N</p> <p><input type="checkbox"/> Prostate disease</p> <p><input type="checkbox"/> Venereal disease</p> <p><input type="checkbox"/> Discharge or sores</p>	<p><u>HABITS</u></p> <p>What are your main interests and hobbies?</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p></p>
<p><u>MUSCULOSKELETAL</u></p> <p><input type="checkbox"/> Joint pain or stiffness</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Broken bones</p> <p><input type="checkbox"/> Muscle spasms or cramps</p> <p><input type="checkbox"/> Weakness</p>	<p>Do you exercise? Y N</p> <p>How many days per week? _____</p> <p>What type of exercise do you do?</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p><u>PERIPHERAL VASCULAR</u></p> <p><input type="checkbox"/> Deep leg pain</p> <p><input type="checkbox"/> Cold hands/feet</p> <p><input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> Thrombophlebitis</p>	<p>Awaken rested? Y N</p> <p>Sleep well? Y N</p> <p>Avg. 6-8 hours sleep? Y N</p>	
<p><u>NEUROLOGICAL</u></p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Paralysis</p>	<p>Enjoy your work? Y N</p> <p>Spend time outside? Y N</p> <p>Take vacations? Y N</p>	

Permission to contact you by email: Yes ___ No ___ Initials _____

APPOINTMENT CANCELLATION POLICY:

I understand that any appointments cancelled or missed without 48 hour notice shall be subject to charge for the appointment time reserved.

_____ (Initials)

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Signature _____ Date _____