

Portland Family - **Male** intake form

Dear patient- thank you for completing this form.

Please answer all questions and **fill in** all bubbles that apply

Patient's name: _____ DOB: _____

Annual visit or new patient concern: _____

Have you had any: hospital stays urgent care/ED visits seen by a specialist
details: _____

Today would you like to talk about: cancer prevention weight issues exercise questions aging concerns
 diabetes prevention family planning hormone concerns STD concerns no concerns

Health habits: Do you: wear seat belts exercise regularly eat a healthy diet wear sunscreen
 are a non-smoker smoker

Over age 70 only: Osteoporosis Screening: family history had previous Dexa/Bone scan Date: _____
 taking Vitamin D supplement _____(dose) taking Calcium _____(dose)

Cholesterol Screening: family history of high cholesterol family history of early heart attack no family history
 no previous cholesterol check currently taking medications for cholesterol
 had previous screening Date: _____

Colon Cancer Screening: wants referral family history of colon cancer previous screening Date: _____
 no family history no previous screen

Prostate Cancer Screening: positive family history no family history wants screening
 had previous screening Date: _____

Immunizations needed: none- pt up to date Pneumovax Tetanus Adacel
 Zostavax-Shingles Influenza- Flu

Current medication(s), including vitamins, supplements/herbs-dose and quantity:

Medical History: Current and/or have a history of: circle all that apply

Heart Disease Hypertension Diabetes Cancer (type) _____ Asthma
Psychiatric Disorder Depression Anxiety Stroke Bleeding disorder Thyroid Disease Kidney Disease
High cholesterol Alcohol abuse Substance abuse Bowel disorders Urinary problems

Others: _____

Allergies to Medications: _____ Other: _____

Surgical History and dates: _____

Hospitalizations and dates: _____

Family History: please fill in any bubble that applies to your family history:

- Father- Date of birth: _____ Alive Deceased High cholesterol Heart Disease
 Hypertension Diabetes Cancer _____ (type) Stroke Thyroid disease
 Kidney disease bleeding disorder Substance abuse Depression
 Psychiatric disorder other _____
- Mother- Date of birth: _____ Alive Deceased High cholesterol Heart Disease
 Hypertension Diabetes Cancer _____ (type) Stroke Thyroid disease
 Kidney disease bleeding disorder Substance abuse Depression
 Psychiatric disorder other _____
- Sibling(s): High cholesterol Heart Disease Hypertension Diabetes
 Cancer _____ (type) Stroke Thyroid disease Kidney disease bleeding disorder
 Substance abuse Depression Psychiatric disorder other _____
- Children: High cholesterol Heart Disease Hypertension Diabetes
 Cancer _____ (type) Stroke Thyroid disease Kidney disease bleeding disorder
 Substance abuse Depression Psychiatric disorder other _____
- Extended Family: High cholesterol Heart Disease Hypertension Diabetes
 Cancer _____ (type) Stroke Thyroid disease Kidney disease bleeding disorder
 Substance abuse Depression Psychiatric disorder other _____

SOCIAL HISTORY

- Smoking: No history of-quit yes socially
Packs per day: ¼ 1/2 1 1 1/2 2 +2
 cigars smokeless tobacco cloves second hand smoke exposure
Alcohol: No history of-quit yes
number of drinks per week: 0-1 1-2 2-3 3-4 4-5 5-6 +6
type of alcohol: varies beer wine hard alcohol
Hx. DUI/DWI: Yes No (history of a Driving under the influence or Driving while intoxicated)
Drug use: none history of-quit current use
Type: cocaine marijuana heroin meth psychotropic other _____
Caffeine: none rarely
cups per day: 1-2 2-3 3-4 4-5 5-6+
of: coffee decaf tea soda chocolate
Exercise: never occasional daily
times weekly: 0-1 2-3 3-5 +5
Marital Status: single married same-sex partner divorced widowed
Children: none yes 1 2 3 4 5 +6 step or adopted children
Current Employer: _____ Occupation: _____
Occupational exposure: no yes lead asbestos blood borne pathogens chemicals
 x-ray/radiation second hand smoke pesticides
Religion we should observe: _____
Travel outside US: No Yes Yes = where? _____
Home smoke detector use: Yes No
Do you feel safe: Yes No sometimes
Has anyone hit, punched, or physically hurt you in the last year or since last seen? Yes No
Are you sexually active: Yes No
New sex partner since last STD test: Yes No
Gender of sexual partner: female male both
History of STDs: No Yes gonorrhea herpes Chlamydia other STD received treatment for it
Do you have a partner with a vaginal infection; abnormal pap; recent STD diagnosis; penile infection or urinary symptom:
 No Yes vaginal infection abnormal pap smear recent STD diagnosis
 penile infection urinary symptoms
Have you signed an Advance directive? Yes No **or a POLST form?** Yes No

CLINIC USE ONLY

Smoker _____

Vitals: WT _____ HT _____ BP _____ 2nd BP _____ Pulse _____ T _____
R _____ HR _____ O2 sat _____ Vision _____ corrected _____
BP supine _____ sitting _____ standing _____ HR supine _____ sitting _____ standing _____