Portland Family - **Female** intake form

Dear patient- thank you for completing this form.

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

Patient's name:____ DOB: ______________________

Annual visit or new patient concern:____

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

details:____

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

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

Breast Cancer Screening: O Desires mammogram O had previous mammogram Date:_______________
O family history O no family history

Osteoporosis Screening: O family history O had previous Dexa/Bone scan Date: _______________
O taking Vitamin D supplement __________(dose) O taking Calcium________ (dose)

Cervical Cancer Screening: O normal pap smears O history of abnormal pap smears O new partner
O monogamous O no previous pap

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

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

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

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

____

____

____

Medical History: Current and/or have a history of: circle all the 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:_____________

GYN History: Date of your last menstrual period?______________ Age period started: _________

Do you have periods still:________ If no- why: Menopausal ____ Hysterectomy____

Problems with them- cramps- irregular bleeding-heavy bleeding: ______________________________________

hot Flashes:_________ vaginal Dryness:_________ vaginal discharge:____________

Date of last Pap: _______________ History of "abnormal" Pap: __________ treatment for it: ________________

Vaginal infections: _______________ urinary incontinence:____________

Sexually active: ________________ Are your sexual partners: Male- Female- or both:____________

New partners since last STD screen: _______________ History of STD's: _______________

What do you use for Birth control: ______________

Did your mother take DES hormone while pregnant with you:________

OB History: Total pregnancies: _________ Total living children: _________

Still births: _________ Miscarriages: _________ Abortions: __________

C-sections: _________ Other comments: ____

Patient Name:___________________________________ **Date of Birth:** ________________

Surgical History and dates: ____
____
Hospitalizations and dates: ____
____

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

- Father- Date of birth:_____________ O Alive O Deceased O High cholesterol O Heart Disease O Hypertension O Diabetes O Cancer _______________ (type) O Stroke O Thyroid disease O Kidney disease O bleeding disorder O Substance abuse O Depression O Psychiatric disorder O other ____
- Mother- Date of birth: ___________ O Alive O Deceased O High cholesterol O Heart Disease O Hypertension O Diabetes O Cancer ____________(type) O Stroke O Thyroid disease O Kidney disease O bleeding disorder O Substance abuse O Depression O Psychiatric disorder O other ___________________________________
- Sibling(s): O High cholesterol O Heart Disease O Hypertension O Diabetes O Cancer ____________(type) O Stroke O Thyroid disease O Kidney disease O bleeding disorder O Substance abuse O Depression O Psychiatric disorder O other__________________________________
- Children: O High cholesterol O Heart Disease O Hypertension O Diabetes O Cancer ___________(type) O Stroke O Thyroid disease O Kidney disease O bleeding disorder O Substance abuse O Depression O Psychiatric disorder O other ____________________________
- Extended Family: O High cholesterol O Heart Disease O Hypertension O Diabetes O Cancer ____________ (type) O Stroke O Thyroid disease O Kidney disease O bleeding disorder O Substance abuse O Depression O Psychiatric disorder O other _________________________________

SOCIAL HISTORY

Smoking: O No O history of-quit O yes O socially
Packs per day: O ¼ O 1/2 O 1 O 1 1/2 O 2 O +2
O cigars O smokeless tobacco O cloves O second hand smoke exposure
Alcohol: O No O history of-quit O yes
number of drinks per week: O 0-1 O 1-2 O 2-3 O 3-4 O 4-5 O 5-6 O +6
type of alcohol: O varies O beer O wine O hard alcohol
Hx. DUI/DWI: O Yes O No
Drug use: O none O history of-quit O current use
Type: O cocaine O marijuana O heroin O meth O psychotropic O other ______________
Caffeine: O none O rarely
cups per day: O 1-2 O 2-3 O 3-4 O 4-5 O 5-6+
of: O coffee O decaf O tea O soda O chocolate
Exercise: O never O occasional O daily
times weekly: O 0-1 O 2-3 O 3-5 O +5
Marital Status: O single O married O same-sex partner O divorced O widowed
Children: O none O yes O 1 O 2 O 3 O 4 O 5 O +6 O step or O adopted children
Current Employer: ____Occupation: _______________________
Occupational exposure: O no O yes O lead O asbestos O blood borne pathogens O chemicals
O x-ray/radiation O second hand smoke O pesticides
Religion we should observe: _________________________
Travel outside US: O No O Yes Yes = where? __________________
Home smoke detector use: O Yes O No
Do you feel safe? O Yes O No O sometimes
Has anyone hit, punched, or physically hurt in the last year or since last seen? O Yes O No
Have you signed an Advance directive? O Yes O No **or a POLST form?** O Yes O No

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CLINIC USE ONLY

Vitals: WT __________ HT __________ BP ____________ 2nd BP _________ Smoker _____________ LMP _______________
Pulse _________ T _____________R _____________ HR _________ O2 sat __________ Vision ___________ corrected________
BP supine ________ sitting ________ standing _________ HR supine ________ sitting _______ standing__________