

# Portland Family Practice - Male intake form

Please complete entirely and bring to your appointment, unless you receive and complete a pre-screening phone call from our office.

**Patient name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**Race:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_ **Language:** \_\_\_\_\_

(If you would like to decline from answering any of the above questions- please add 'decline' to the line.)

**Annual visit or new patient concern:** \_\_\_\_\_

**Have you had any:**  hospital stays  urgent care/ED visits  seen by a specialist(s) 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  
 a non-smoker  smoker

Over age 70 only: Osteoporosis Screening:  family history  taking Vitamin D supplement \_\_\_\_\_ (dose)  
 taking Calcium \_\_\_\_\_ (dose)  previous screening Date: \_\_\_\_\_

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  
 previous screening Date: \_\_\_\_\_

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

Prostate Cancer Screening:  family history of prostate cancer  no family history  wants screening  
 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 allergy type(s):** \_\_\_\_\_

**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 \_\_\_\_\_



# REVIEW OF SYSTEMS

Please fill in any bubble that applies to you. If none, please fill in 'None of the following'

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

In the past two weeks have you experienced any of the following? \* :

Constitutional:  None of the following  fever  weight loss  weight gain  
 fatigue  loss of appetite  night sweats

Cardiology:  None of the following  chest pain with exertion  dizziness  
 shortness of breath  palpitations  feet or hand swelling

Dermatology:  None of the following  
 rash  hair loss  skin changes  moles  sores

Endocrinology:  None of the following  excessive urination  excessive thirst  
 excessive hunger  heat/cold intolerance  hair loss  hot flashes

Gastroenterology:  None of the following  nausea  vomiting  diarrhea  
 constipation  blood in stool  difficulty swallowing

Hematology:  None of the following  easy bruising  bleeding gums  enlarged lymph glands

Musculoskeletal:  None of the following  joint pain  muscle pain  muscle weakness

Neurology:  None of the following  headache  numbness in hands or feet  
 tingling in hands or feet  fainting  seizures  trouble walking

Ophthalmology:  None of the following  visual changes  glasses  contacts

Psychology:  None of the following  depression  anxiety  insomnia  crying

Respiratory:  None of the following  shortness of breath  cough  
 congestion  chest pain with breathing

Urology:  None of the following  painful urination  frequency  urgency  
 blood in urine  incontinence  incomplete emptying

Infectious Disease:  None of the following  fever  nausea  vomiting  sick contacts

Breast:  None of the following  nipple discharge  pain in breasts  masses

**For males only:**

Male reproductive:  None of the following  frequent voiding at night  slow stream  
 difficulty with erection  diminished sex drive  penile discharge

**For females only:**

Female reproductive:  None of the following  difficult or painful sex  painful periods  
 bleeding after sex  irregular bleeding

NOTE: All of these concerns are important and some may need to be addressed individually in a future appointment.

NAME: \_\_\_\_\_  
DOB: \_\_\_\_\_

DATE: \_\_\_\_\_

### PATIENT HEALTH QUESTIONNAIRE (PHQ – 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Your provider will review your answers with you and discuss the results at your visit.

Please select only one answer per question and an use "x to indicate your choice	Not at all	Several days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Feeling down, depressed or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Trouble falling or staying asleep, or sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Feeling tired or having little energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Poor appetite or overeating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Feeling bad about yourself – or that you're a failure or have let yourself or your family down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Trouble concentrating on things, such as Reading the newspaper or watching television?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. If you are experiencing any of the problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all       Somewhat difficult       Very difficult       Extremely difficult

11. In the past two years, have you felt depressed or sad most days, even if you felt ok sometimes?

- Yes     No

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12. Are you currently seeing a Mental Health Provider outside of Portland Family Practice?

- Yes     No

If yes, who: \_\_\_\_\_

**PORTLAND FAMILY PRACTICE**

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Portland Oregon 97232

[www.portlandfp.com](http://www.portlandfp.com)

Phone: 503-233-6940  
Fax: 503-236-2676

**Patient Contact Information:**

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**Local Relative/Friend not living in the same household:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**By signing below, I agree I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.**

**By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Patient)

(OR)

**By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Patient representative)

**Description of Representative's Authority:** \_\_\_\_\_