Portland Family Practice- **Female** 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: O hospital stays O urgent care/ED visits O seen by a specialist(s)
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 a non-smoker O a 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 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):***____________

GYN History: Age period started: ________ Are you Menopausal: ______ Had a Hysterectomy:______
Problems with: cramps, irregular or heavy bleeding or other: ______________________________________
Do you have: hot flashes:________ vaginal dryness:________ vaginal discharge:__________
vaginal infections: ____________ urinary incontinence:__________
Date of last Pap: ____________ History of "abnormal" Pap: ________ treatment for it: _____________
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: ____

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

-Please complete both sides of form-

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 Status: O **I have never smoked** **Additional options:** O Cloves O Cigars O Chew O Second hand smoke exposure

O **Current smoker:** How often do you smoke cigarettes or other? O Every day O some days, but not every day
How many cigarettes a day do you smoke? O 5 or less O 6-10 O 11-20 O 21-30 O 31 or more
How soon after you wake up do you smoke your first cigarette? O within 5 minutes O 6-30 minutes
O 31 minutes -1 hour O after 1 hour
Are you interested in quitting? O Ready to quit O Thinking of quitting O Not ready to quit

O **Former Smoker:** How long has it been since you last smoked? O Less than 1 month O 1-3 months
O 3-6 months O 6-12 months O 1-5 years O 5-10 years O More than 10 years

Alcohol: Did you have a drink containing alcohol in the past year? O Yes O No
If yes: How often did you have a drink containing alcohol in the past year? O monthly or less
O 2 to 4 times a month O 2 to 3 times a week O 4 or more times a week
How many drinks did you have on a typical day when you were drinking in the past year? O 1 or 2 drinks
O 3 or 4 drinks O 5 or 6 drinks O 7 to 9 drinks O 10 or more drinks
How often did you have 6 or more drinks on one occasion in the past year? O never O less than monthly
O monthly O weekly O daily or almost daily

Hx. DUI/DWI: (history of driving under the influence or while intoxicated) O No O Yes Date: __________________

Drug use: O none O history of-quit/Date: ________________ 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 sodaO chocolate

Exercise: O never O occasional O daily Times weekly: O 0-1 O 2-3 O 3-5 O +5

Relationship Status: Married: O Yes O No
If no: status= O Single O Divorced O Widowed O life-partner O same sex partner

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 you observe: __________________________

Travel outside US: O N O Yes Yes = where? ___________________ *Home smoke detector use*: O Yes O No

Do you feel safe? O Yes O No O most of the time

Has anyone hit, punched, or physically hurt in the last year or since last seen? O Yes O No

Sexual history: Have you had sex in the last 12 months? (Vaginal, rectal, or oral)
O Yes O no With: O Men O Women O both men and women
Do you use a method of STD prevention/protection? (condom or dental dam) O Yes O No
How often: O All of the time O 90% O Most of the time O Half of the time O 80% O Some of the time
O 70 % O 60% O 20% O 10% O 0%
Would you like to discuss STD prevention with your provider? O Abstinence O condoms O other _____________
Have you ever had an STD (sexually transmitted disease) O Yes O No
If yes, please specify: O Chlamydia O Gonorrhea O Syphilis O Herpes O other _______________

Date of last Menstrual period: ___/___/_____

Have you signed an Advance directive? O Yes O No **or a POLST form?** O Yes O No

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

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

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

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

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

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

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

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

Ophthalmology: O None of the following O visual changes O glasses O contacts

Psychology: O None of the following O depression O anxiety O insomnia O crying

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

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

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

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

For males only:
Male reproductive: O None of the following O frequent voiding at night O slow stream O
difficulty with erection O diminished sex drive O penile discharge
For females only:
Female reproductive: O None of the following O difficult or painful sex O painful periods
O bleeding after sex O irregular bleeding

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

NAME: ____ DATE: _________________

DOB: ____

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?	☐	☐	☐	☐
2) Feeling down, depressed or hopeless?	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much?	☐	☐	☐	☐
4) Feeling tired or having little energy?	☐	☐	☐	☐
5) Poor appetite or overeating?	☐	☐	☐	☐
6) Feeling bad about yourself – or that you're a failure or have let yourself or your family down?	☐	☐	☐	☐
7) Trouble concentrating on things, such as Reading the newspaper or watching television?	☐	☐	☐	☐
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?	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

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
541 NE 20th Ave. Suite 210
Portland Oregon 97232

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: _____________________________