Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

11900 SW Greenburg Road
Tigard, OR 97223
Phone: 503.620.5556
Fax: 503.624.0118

New Patient Adult Intake Form

Name:____ Date:____/____/_______
Date of Birth:____/____/_______ Legal sex:☐Male ☐Female SSN: _____________________
Gender: ☐Woman ☐Man ☐Trans Woman ☐Trans Man ☐Non-binary ☐Genderqueer ☐Agender
☐Not listed: _________
Preferred Language: _______________ Best Phone Number: ____________________
Is it okay to leave a detailed message concerning your appointment? ☐Yes ☐No
Please list any health concerns that you have at this time:____
____

1. Are you ☐Single ☐Married ☐Partnered ☐Divorced or Separated ☐Widowed ☐Other: ___________
2. Where did you grow up? _______________________
3. What kind of **work** do you do or, if retired, what did you do? ________________________
4. What level of education did you complete? ________________________
5. When was the last time you were **seen by a primary care doctor**? _____________________
   Who did you see? _____________________________________
6. Do you have an Advance Directive or Living Will? ☐ Yes ☐No
7. Do you have a POLST (Physician Order for Life Sustaining Treatment)? ☐Yes ☐No

ALLERGIES

8. Have you ever had any **allergic reaction (bad effect)** to a medicine or shot? ☐ No ☐ Yes
   Please write the name of the medicine or shot and the effect you had: ____________________________
9. Do you get a significant **allergic reaction (bad effect)** from anything else? ☐ No, I have no allergies.
   ☐ Yes, please list: ____

MEDICINES

10. Please list any **prescription medications or supplements** that you have been prescribed and/or are currently taking:
    ☐ No, I do not take any prescription medicines.
    ☐ Yes. List your medicines below **OR** ☐ I brought my pill bottles or a list
    Pharmacy Name: ______________________________

Medicine or Supplement Name	Strength or Amount	How many pills or doses do you take at a time?			
EXAMPLE: Furosemide	20 mg	2 morning	1 noon	1 dinner	2 bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed

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MEDICAL HISTORY

12. Have you **ever** had any of the following health problems? *Check all that apply.*

- ☐ Abnormal pap test
- ☐ Allergies
- ☐ Anemia (low iron, low blood count)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer (type: _______________)
- ☐ Cataracts
- ☐ Congestive heart failure (CHF)
- ☐ Bowel disorder
- ☐ Clotting disorder
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Depression (feeling low or blue)
- ☐ Diabetes (high blood sugar)
- ☐ Emphysema (lung disease)
- ☐ GERD (heartburn, acid reflux)
- ☐ Glaucoma
- ☐ Gout (joint pain in toes)
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heart attack
- ☐ Heart murmur (extra noise heart makes)
- ☐ Hepatitis (disease that affects the liver)
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Jaundice (skin and eyes turn yellow)
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Meningitis
- ☐ Osteoporosis (weak bones)
- ☐ Prostate problems
- ☐ Seizures
- ☐ Sexually transmitted disease
- ☐ Shingles (painful skin rash)
- ☐ Sickle cell (disorder affecting red blood cells)
- ☐ Skin problems
- ☐ Stroke
- ☐ Substance abuse (illegal drugs, drug problem)
- ☐ Thyroid disease
- ☐ Tuberculosis (TB, lung disease)
- ☐ Ulcers (open sores)
- ☐ Urinary problems (problem peeing)

SURGICAL HISTORY

13. Have you **ever** had **surgery**? ☐ No, I have never had surgery ☐ Yes. Please list each surgery below.

Surgery	Date

FAMILY PLANNING

14. Do you have sex with ☐ Men ☐ Women ☐ Both ☐ I don't have sex
If you use birth control, what type do you use? *Check all that apply.*

- ☐ Abstinence
- ☐ Birth Control Pills
- ☐ Condom
- ☐ Diaphragm
- ☐ Injection
- ☐ Inserts
- ☐ Implant
- ☐ IUD
- ☐ Post-menopausal
- ☐ Rhythm (calendar tracking)
- ☐ Tubal Ligation (tubes tied)
- ☐ Vasectomy
- ☐ Withdrawal or pullout method
- ☐ Other: ___________

15. If applicable: How many times have you been pregnant? ______ How many deliveries? _____

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FAMILY HISTORY

16. Have any of your **family members** ever had any of the following health problems? *Check all that apply.*

	Name	Alive?	No know history	Cancer	Diabetes	Heart Problems	High Blood Pressure	High Cholesterol	Mental Illness	Stroke	Thyroid Disease	Other
Mother												
Father												
Sister												
Sister												
Brother												
Brother												

EXERCISE

17. Do you exercise 2 or more days a week? ☐ Yes ☐ No

SPECIALTY SERVICES

18. Are you **currently** seeing any other doctors?

Doctor's Name: ______________________ Type of Doctor: _________________________
When Last Seen: ____________________ Phone Number: _________________________

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Anything else we should know?

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SYMPTOM REVIEW

18. Please rate current symptoms below that apply during the PAST TWO WEEKS.
Do not mark if symptoms aren't present. However if you do, rate symptoms: **1** = Mild, **2** = Moderate, **3** = Severe.

Head and Face

Headaches	1	2	3
Allergies	1	2	3
Memory Loss	1	2	3
Other:	1	2	3

Eyes

Poor Vision	1	2	3
Eye Pain	1	2	3
Inflammation	1	2	3
Other:	1	2	3

Ears

Poor Hearing	1	2	3
Earaches	1	2	3
Discharge	1	2	3
Ringing	1	2	3
Other:	1	2	3

Nose

Frequent Colds	1	2	3
Sinus Trouble	1	2	3
Bleeding	1	2	3
Difficulty Breathing	1	2	3
Other:	1	2	3

Mouth

Gum Problems	1	2	3
Teeth Problems	1	2	3
Jaw Problems	1	2	3
Unusual Tastes	1	2	3
Other:	1	2	3

Throat

Sore Throat	1	2	3
Hoarseness	1	2	3
Difficulty Swallowing	1	2	3
Other:	1	2	3

Body Pain

Arthritis/Rheumatoid	1	2	3
Muscle Pain	1	2	3
Difficulty Laying Flat	1	2	3
Tightness in Chest	1	2	3
Other:	1	2	3

Circulation

Palpitation	1	2	3
High Blood Pressure	1	2	3
Low Blood Pressure	1	2	3
Bruise Easily	1	2	3
Bleed Easily	1	2	3
Slow Wound Healing	1	2	3
Cold Limbs	1	2	3
Other:	1	2	3

Gastrointestinal

Excess Thirst	1	2	3
Excess Appetite	1	2	3
Weight (Gain) (Loss)	1	2	3
Digestive Pain	1	2	3
Nausea	1	2	3
Vomiting	1	2	3
Diarrhea	1	2	3
Constipation	1	2	3
Blood in Stool	1	2	3
Colon Problems	1	2	3
Hemorrhoids	1	2	3
Other:	1	2	3

Urination

Frequent	1	2	3
Difficulty	1	2	3
Nighttime	1	2	3
Bleeding	1	2	3
Painful	1	2	3
Describe:	1	2	3

Skin

Rashes	1	2	3
Dryness	1	2	3
Moles or Lumps	1	2	3
Excess Sweat	1	2	3
Night Sweat	1	2	3
Rarely Sweat	1	2	3
Other:	1	2	3

Neurological

Dizziness	1	2	3
Nervousness	1	2	3
Tremors	1	2	3
Seizures	1	2	3
Numbness/tingling	1	2	3
Loss of Balance	1	2	3
Nerve Pain	1	2	3
Other:	1	2	3

Energy

Low (fatigue)	1	2	3
High	1	2	3

Women's Health

Pelvic Pain	1	2	3
Menopausal sx	1	2	3
Vaginal Discharge	1	2	3
Difficulty Conceiving	1	2	3
Sexual Difficulties	1	2	3
Other:	1	2	3

Number of Pregnancies:
Number of Living Children:

Menstrual Cycle

Irregular	1	2	3
Excess Blood	1	2	3
Lack of Blood	1	2	3
Dark Colored Blood	1	2	3
Light Colored Blood	1	2	3
Bleeding Midcycle	1	2	3
Clotting	1	2	3
Water Retention	1	2	3
Breast Tenderness	1	2	3
Emotional Changes	1	2	3
Painful (cramping)	1	2	3

Sleep

Insomnia	1	2	3
Drowsiness	1	2	3
Dream Disturbance	1	2	3
Describe:	1	2	3

Mental Health

Depression	1	2	3
Anxiety	1	2	3
Irritability	1	2	3
Other:	1	2	3

Men's Health

Prostate Problems	1	2	3
Genital Pain	1	2	3
Genital Swelling	1	2	3
Sexual Difficulties	1	2	3
Other:	1	2	3