

New Patient Adult Intake Form

Name:	Date:/
Date of Birth://	Legal sex: Male Female SSN:
	ans Woman 🗌 Trans Man 🔲 Non-binary 🔲 Genderqueer 🗌 Agender
Not listed:	
Preferred Language:	Best Phone Number:
Is it okay to leave a detailed mess	sage concerning your appointment? 🗌 Yes 🗌 No
Please list any health concerns th	at you have at this time:
	Partnered Divorced or Separated Widowed Other:
2. Where did you grow up?	
3. What kind of work do you do o	or, if retired, what did you do?
4. What level of education did yo	u complete?
5. When was the last time you we	ere seen by a primary care doctor?
Who did you see?	
6. Do you have an Advance Direct	tive or Living Will? 🗌 Yes 🔲 No
7. Do you have a POLST (Physician	n 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 n	nedicine 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						



Southwest Family Physicians

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

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**? \Box No, I have never had surgery \Box Yes. Please list each surgery below.

Surgery	Date

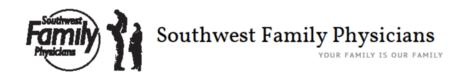
FAMILY PLANNING

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

- InsertsImplant
- Birth Control Pills
- □ Condom
- Diaphragm
- Injection

- IUD
 Bost monopol
- Post-menopausalRhythm (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? _____



FAMILY HISTORY

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

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

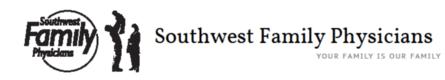
EXERCISE

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

SPECIALTY SERVICES

18. Are you currently seeing a	iny other doctors?	
Doctor's Name:	Type of Doctor:	
When Last Seen:	Phone Number:	
Doctor's Name:	Type of Doctor:	
When Last Seen:	Phone Number:	
Doctor's Name:	Type of Doctor:	
When Last Seen:	Phone Number:	

Anything else we should know?



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

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				Circulation				Neurological				Sleep		
Headaches	1	2	3	Palpitation	1	2	3	Dizziness	1	2	3	Insomnia	1	23
Allergies	1	2	3	High Blood Pressure	1	2	3	Nervousness	1	2	3	Drowsiness	1	23
Memory Loss	1	2	3	Low Blood Pressure	1	2	3	Tremors	1	2	3	Dream Disturbance	1	23
Other:	1	2	3	Bruise Easily	1	2	3	Seizures	1	2	3	Describe:	1	23
Eyes				Bleed Easily	1	2	3	Numbness/tingling	1	2	3	Mental Health		
Poor Vision	1	2	3	Slow Wound Healing	1	2	3	Loss of Balance	1	2	3	Depression	1	23
Eye Pain	1	2	3	Cold Limbs	1	2	3	Nerve Pain	1	2	3	Anxiety	1	23
Inflammation	1	2	3	Other:	1	2	3	Other:	1	2	3	Irritability	1	23
Other:	1	2	3	Gastrointestinal				Energy				Other:	1	23
Ears				Excess Thirst	1	2	3	Low (fatigue)	1	2	3			
Poor Hearing	1	2	3	Excess Appetite	1	2	3	High	1	2	3	Men's Health	1	n n
Earaches	1	2	3	Weight (Gain) (Loss)	1	2	3	Women's Health				Prostate Problems		23 23
Discharge	1	2	3	Digestive Pain	1	2	3	Pelvic Pain	1	2	h	Genital Pain		23
Ringing	1	2	3	Nausea	1	2	3			2		Genital Swelling		23
Other:	1	2	3	Vomiting	1	2	3	Menopausal sx		2		Sexual Difficulties		23
Nose				Diarrhea	1	2	3	Vaginal Discharge Difficulty Conceiving		2		Other:	T	23
Frequent Colds	1	2	3	Constipation		2		Sexual Difficulties		2				
Sinus Trouble	1	2	3	Blood in Stool		2		Other:		2				
Bleeding	1	2	3	Colon Problems		2					5			
Difficulty Breathing	1	2	3	Hemorrhoids		2		Number of Pregnanci						
Other:	1	2	3	Other:	1	2	3	Number of Living Chil	dre	en:				
Mouth				Urination				Menstrual Cycle						
Gum Problems	1	2	3	Frequent	1	2	3	Irregular	1	2	3			
Teeth Problems	1	2	3	Difficulty		2		Excess Blood			3			
Jaw Problems	1	2	3	Nighttime		2		Lack of Blood			3			
Unusual Tastes	1	2	3	Bleeding		2		Dark Colored Blood			3			
Other:	1	2	3	Painful		2		Light Colored Blood			3			
Throat				Describe:	1	2	3	Bleeding Midcycle			3			
Sore Throat	1	2	3	Skin				Clotting			3			
Hoarseness	1	2	3	Rashes	1	2	3	Water Retention	1	. 2	3			
Difficulty Swallowing	1	2	3	Dryness	1	2	3	Breast Tenderness			3			
Other:		2		Moles or Lumps		2		Emotional Changes			3			
Body Pain				Excess Sweat		2		Painful (cramping)			3			
Arthritis/Rheumatoid	1	2	3	Night Sweat		2								
Muscle Pain		2		Rarely Sweat		2								
Difficulty Laying Flat		2		Other:	1	2	3							
Tightness in Chest		2					1							