Salem Wellness Clinic
1395 Liberty St. SE Salem OR 97302
Phone 503-581-9355 Fax 503-581-3960

Referred by:_____ Today's Date:_____

Patient Information and Medical History Form (Please Print) MALE FORM

Primary Care Physician:			**Have you been a patient of Salem Women's Clinic in the past?** __ Yes __ NO
PATIENT (Please check one) __ Single __ Married __ Divorced __ Widowed __Live with Partner	**Last** **First** **MI**		**Date of Birth** **Age**
	Sex:	**Ethnicity/Race:** ___ American Indian or Alaska Native ___Asian ____Native Hawaiian or Other Pacific ____Black ___White ___ Hispanic ___ Other ___Decline to Answer	
	Native Language:	**Name of your Pharmacy**	
	Are you fluent in English?	**Pharmacy Address/Phone**	
	Preferred Language:	**Occupation:**	

Spouse/Partner's Name		**Date of Birth**
Guardian's Name (if under 18)		**Date of Birth**
IN CASE OF EMERGENCY NOTIFY	**Name**	**Relation**
	Address	**Phone #**

Do you have a Medical Alert Bracelet, Jewelry or other device? __Yes __No

MEDICAL ALERT (Please check)	Alzheimer's or memory Impairment___ Anaphylactic reaction to food, drug or insect___ Pacemaker or Other Medical Equipment____ Diabetes___ Hypoglycemia____ Other___	Cancer or Transplant ___ Kidney Disease___ Epilepsy or Seizures ___ Asthma___ On blood Thinners___ Special Needs___ Visual or Hearing Impairment____

Do you have an **ADVANCED DIRECTIVE? YES NO** If yes, please provide the office with a copy for your chart.
If no, would you like the ADVANCED DIRECTIVE Paperwork? **YES NO**

Do you have a registered **POLST**? **YES NO** **(Portable Medical Orders (**POLST forms) are medical orders that travel with the patient and are **for people who are seriously ill or have advanced frailty)**

ALLERGIES TO MEDICATIONS OR ENVIRONMENTAL	
Medications or Other (Environmental)	**Reaction**
Food Triggers, sensitivities or Allergies	**Reaction**

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Patient's Name: _____ Guardian's Name (if under 18): _____

LIST *ALL* PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS			
Name	**Dose (How many?)**	**Frequency (How often you take the medication?)**	**Ordering Provider**

***If you need additional space to list all medications and supplements, please list at the end of the patient form or you may ask the front desk for additional blank paper.**

PAST SURGICAL HISTORY			
Date	**Surgery**	**Date**	**Surgery**

HEALTH HABIT HISTORY

Do you now/have you ever smoked? **YES NO** If yes, how long have/did you smoke? _____ How many packs per day_____
Did you quit? **YES NO** If yes what year did you quit? _____ How many alcoholic beverages do you drink per week?_____
How many days per week do you exercise? _____ What do you do for exercise?_____
Do you drink coffee? **YES NO** If yes, how many cups per day (1 cup= 8 ounce)? _____
Do you drink soda? **YES NO** If yes, how many ounces per day (a regular soda can is 12 ounces)?_____
Do you drink energy drinks? **YES NO** If yes, what do you drink? _____ How many servings/ounces per day?_____
Please check if you use any of the following:
Narcotics/IV Drug Use____ Cocaine____ Chronic opioid use____ Chronic use of Benzodiazepines (like Xanax, Ativan, Klonopin?___
Marijuana____ Do you smoke, Vape, use Edibles or Oils? _____ HEMP, CBD products with less than 0.03% THC?____
NutraSweet or other regular use of artificial sweeteners? _____
Do you depend on public transportation /or TripLink to come to your appointments? **YES NO**
Do you use any of the following equipment? (Please circle all that apply)
Cane Walker Electric Scooter Wheelchair Bi-PAP CPAP Nightguard Mouthpiece for Apnea

Do you use car seatbelts consistently? **YES NO** Do you text while driving? **SOMETIMES OFTEN NEVER**
Do you use sunscreen? **ALL YEAR ROUND ONLY IN THE SUMMERR NEVER** If you own guns, are they safely locked? **YES NO**

Please describe what type of diet and/or dietary restrictions you follow (omnivorous, vegetarian, vegan, ketogenic, paleo, gluten free, dairy free etc.)

_____

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Patient's Name: _____ Guardian's Name (if under 18): _____

FAMILY MEDICAL HISTORY

Use the following legend to indicate member of the family that has the conditions listed on the table below. Additional spaces are provided to add conditions and information not listed.

M= Mother F= Father MG= Maternal Grandparents PG= Paternal Grandparents B= Brother S= Sister AD= Additional Siblings

Condition	Family member with the condition or disease
Cancer Type?	
Diabetes	
Heart Disease	
Stroke	
High Blood Pressure	
High Cholesterol	
Osteoporosis	
Kidney Disease	
Mental Health Problems	
Blood disease or Anemia	
Thyroid Disease	
Inflammatory Bowel Disease	
Deep Venous Thrombosis	

If your mother, father, brother or sisters are deceased, please list the age at the time of death and the cause.

Relationship	Cause of Death	Age at Death	Relationship	Cause of Death	Age at Death

YOUR HEALTH HISTORY

(Check if you had or have any of the following)

Headache/Migraines	Emphysema/COPD	Peripheral Vascular Disease	Anemia	Kidney Disease
Seizures/Epilepsy	Abnormal Heart rhythm	Heartburn/GERD	Diabetes	Kidney Stones
Allergies (any)	Atrial Fibrillation	Stomach Ulcers	Gout	Kidney Transplant
Stroke or Transient Ischemic Attacks	Heart Attack/Failure	Gallbladder Disease	Anxiety	HIV/AIDS
Sleep Apnea	High Blood Pressure	Irritable Bowel Syndrome	Depression	Osteoporosis
Thyroid Disease	High Cholesterol	Colitis or Chron's Disease	Arthritis	Obesity
Asthma	Heart Murmur	Hepatitis	Chronic Pain	Chronic Stress
Gastric Bypass	Physical Abuse	Sexual Abuse	Emotional Abuse	Cancer

Any other Health History:

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PREVENTATIVE HEALTH HISTORY (male and female) (Check if you have had any of the following preventative health screening exam)			
Test	**Date** (*month/year)*	**Results**	**Physician**
Colonoscopy			
Cholesterol Screening			
Blood sugar Screening			
Cardiac Stress Test			
Bone Density scan			
Physical Exam			

Vaccine type	**Date**	**Vaccine type**	**Date**
Tetanus (Td)		Influenza (Flu)	
Pneumonia		Shingles	
Hepatitis B		HPV	
Other:			

ACCIDENT-TRAUMA
Have you ever had a severe accident? **YES** **NO** Do you have any metal pins/plates in your body? **YES** **NO** Please describe.

PAIN
In the past 6 months, have you had a problem with pain? **YES** **NO** Where?
Do you have a diagnosis or history of Fibromyalgia? **YES** **NO**
Do you have a diagnosis of chronic pain? **YES** **NO**
Are you currently using opioids for chronic pain? **YES** **NO** Who is the Prescriber?
Do you get treatments from a chiropractor, massage therapist and/or acupuncturist? **YES** **NO** Who is the provider?

MALE PREVENTATIVE HEALTH HISTORY (Check if you have had any of the following MALE preventative health screening exam)			
Test	**Date** (*month/year)*	**Results**	**Physician**
Last PSA			
Last Rectal exam			
Sexually Transmitted Infection Screen			
Genital Exam			
Do you do genital self-exams? YES NO How often?_____			

MALE SEXUAL HISTORY (Check all that apply)				
	Not sexually active			Erectile Dysfunction
	Sexually active			Monogamous relationship
	Decreased Sexual desire			Multiple partners
	Penile/Testicular Pain with intercourse			Same sex Partner
	Unable to Reach orgasm			Number of Lifetime Partners? _____
	Premature Ejaculation			Other:
	History of sexually transmitted infections			

Do you have a history of infertility? **YES** **NO**

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CURRENT SYMPTOMS

Check all that apply only to you NOW.

___ Night sweats/Hot flushes

___ Weight gain

___ Heat Intolerance

___ Cold Intolerance

___Unusual hair growth

___ Loss of hair

___ Skin complexion problems

___ Dry skin

___ Oily skin

___ Worrisome moles

___ Trouble breathing

___ Shortness of breath

___ Chest pain

___ Cough

___ Chronic nose or sinus problems

___ Frequent Headaches

___ Chest Pain

___ Irregular heartbeat

___ Trouble with eyesight

___ Trouble with ears/hearing

___ Eye pain

___ Dry eyes

___ Ear pain

___ Numbness of arms/legs/feet/hands

___ Muscle pain

___ Muscle spams

___ Restless legs

___ Joint pain,
Where?_____

___ Joint swelling

___ Frequent headaches

___ Migraines

___ Feel nervous or anxious

___ Feel depressed

___ Sleep Problems/Insomnia/Frequent nighttime awakening

___ Marital difficulties

___ Sexual problems

___ Stomach pain

___ Diarrhea

___ Constipation

___ Routine laxative use
What?_____

___ Ulcers

___ Abdominal bloating

___ Abdominal pain

___ Hemorrhoids

___ Food Intolerance/allergy

___ Rectal bleeding

___ Difficulty urinating

___ Frequent urination

___ Urinary incontinence

___ Blood in urine

___ Blood in semen

___ Pelvic Pain

___ Breast pain

Any additional health concerns, not listed above:

_____
_____
_____
_____
_____
_____
_____
_____

Reviewed by:_____ **Date:**_____