# 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) FEMALE 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___<br>Anaphylactic reaction to food, drug or insect___<br>Pacemaker or Other Medical Equipment____<br>Diabetes___ Hypoglycemia____ Other___ | Cancer or Transplant ___ Kidney Disease___<br>Epilepsy or Seizures ___ Asthma___<br>On blood Thinners___ Special Needs___<br>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** |
| | |
| | |

## Patient Information and Medical History Form (Please Print)

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** |
| | | | |
| | | | |
| | | | |
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| | | | |

***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.)

_____

# Patient Information and Medical History Form (Please Print)

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.

**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<br>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:

## Patient Information and Medical History Form (Please Print)

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

| **PREVENTATIVE HEALTH HISTORY** (Check if you have had any of the following screenings) | | | |
|---|---|---|---|
| **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**<br>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**<br>Who is the provider? |

| **FEMALE PREVENTATIVE HEALTH HISTORY**<br>(Check if you have had any of the following FEMALE preventative health screening exam) | | | |
|---|---|---|---|
| **Test** | **Date** (*month/year)* | **Results** | **Physician** |
| Last mammography | | | |
| Last Pap screening | | | |
| Sexually Transmitted Infection Screen | | | |
| Pelvic Exam | | | |
| Do you self-breast exam? YES NO How often?_____ | | | |

| **OB/GYN HISTORY** | | | | |
|---|---|---|---|---|
| **History of** | **Date** (*month/year)* | **LIST NUMBER OF:** | | |
| History of abnormal Pap | | Pregnancies____ | Premature babies___ | Living Children___ |
| History of LEEP or Cone biopsy | | Full term babies___ | Abortions/Miscarriages___ | |

| **FEMALE SEXUAL HISTORY** (Check all that apply) | | | | |
|---|---|---|---|---|
| | Not sexually active | | | Monogamous relationship |
| | Sexually active | | | Multiple partners |
| | Decreased Sexual desire | | | Same sex Partner |
| | Vaginal/Vulvar Pain with intercourse | | | Number of Lifetime Partners? _____ |
| | Unable to each orgasm | | | History of Infertility |
| | Sexually Transmitted Infections | | | Other: |

# Patient Information and Medical History Form (Please Print)

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

## 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:**_____