Quince Orchard Medical Center

Patient Information

Patient Name: _____ Date:_____

DOB: _____ Gender: ☐ Female ☐Male ☐ Non-Binary

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Email: _____

Work Phone: _____ Cell Phone: _____

Where may we leave a detailed message including your medical information, if necessary?

☐ Home ☐ Work ☐Cell

Social Security Number: _____ - _____ - _____

Referred by: _____

Occupation: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name & Address: _____

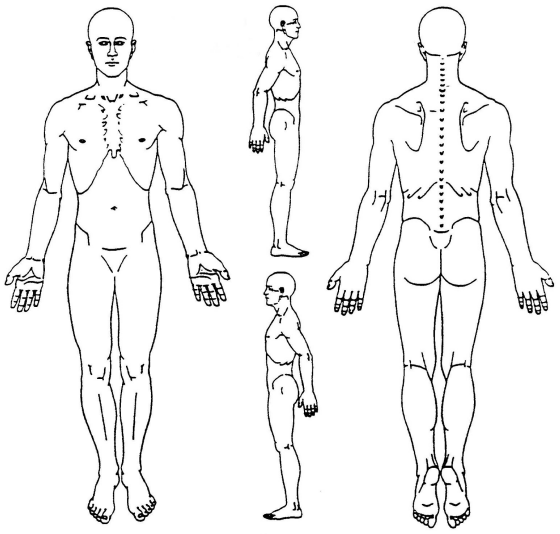
Pharmacy Phone: _____

Current Complaints: _____

_____

_____

Please use the illustration below to diagram your symptoms:



X=Pain; B=Burning; N = Numbness: O=Other Symptoms

When Did Symptoms Start: _____
What Makes You Feel Better: _____
What Makes You Feel Worse: _____
Symptoms Are: ☐ Constant ☐ Come & Go
Symptoms Are: ☐ Improving ☐ Getting Worse ☐ About the Same
Condition Due To: ☐ Auto Accident ☐ Work Injury ☐ Unknown ☐ Other
I Have: ☐ Loss of Bowel or Bladder Control ☐ Pain on Coughing/Sneezing

Please list your top three health goals:

_____
_____
_____

Current Medical History

Date of Last Physical Exam: _____
Any Allergies to Medications? _____
_____
_____
Current Medications (including over-the-counter): _____
_____
_____
Current Supplements (Vitamins, Herbs, Etc.) _____
_____
_____
Are you using any prescription or over-the-counter blood thinning medications? Please List:
_____
_____
_____

Current Assistive Devices (Cane, Crutches, Walker, Etc.)_____

Radiological Tests Related to Current Medical Complaint: ☐ X-ray ☐MRI ☐CT Scan ☐EMG ☐NCV
☐Other: _____

Prior Treatments for Current Condition (surgery, injections, acupuncture, etc.)_____
_____
_____

Medical History and Review of Symptoms

Do you currently smoke? ☐ Yes ☐No How much? _____
Have you smoked in the past? ☐ Yes ☐ No
Other Habits: ☐ Alcohol ☐ Coffee ☐ Drugs ☐ Other: _____

Please check all health concerns that you are currently experiencing (if applicable)

☐ Digestive Issues
☐ Exercise Inefficiency
☐ Insomnia
☐ Lack of Focus and Motivation “Brain Fog”
☐ Low Energy
☐ Low Sex Drive
☐ Low Testosterone
☐ Menopause Symptoms
☐ Menstrual Irregularity / Premenstrual Symptoms
☐ Mood Issues
☐ Pain
☐ Weight Gain
☐ Other: _____

Please check all that apply to your medical history or immediate family:

Condition	Self	Immediate Family	Condition	Self	Immediate Family
Osteoporosis	☐	☐	High/Low Blood Pressure	☐	☐
Osteoarthritis	☐	☐	Abnormal Cholesterol	☐	☐
Bone Fracture	☐	☐	Asthma	☐	☐
Rheumatoid Arthritis	☐	☐	Other Breathing Conditions	☐	☐
Whiplash	☐	☐	Anemia	☐	☐
Dizziness	☐	☐	Angina, Chest Pain	☐	☐
Balance Loss	☐	☐	Heart Valve Disorder	☐	☐
Muscle Weakness	☐	☐	Irregular Heart Rhythm	☐	☐
Type 1 Diabetes	☐	☐	Heart Failure/Attack	☐	☐
Type 2 Diabetes	☐	☐	Blood Clots	☐	☐
Anemia	☐	☐	Skin Conditions	☐	☐
Hernia	☐	☐	Headaches	☐	☐
Stroke	☐	☐	Migraines	☐	☐
Thyroid Disorder	☐	☐	Fatigue	☐	☐
Auto-Immune Disorder	☐	☐	Stress	☐	☐

Condition	Self	Immediate Family	Condition	Self	Immediate Family
Lyme's Disease	☐	☐	Seizures	☐	☐
HIV	☐	☐	Weight Problems	☐	☐
Gout	☐	☐	Eating Disorder	☐	☐
Liver Disease	☐	☐	Vitamin or Mineral Deficiency	☐	☐
Kidney Disease/Stones	☐	☐	Alcohol Abuse	☐	☐
Gastrointestinal Concerns	☐	☐	Drug Abuse	☐	☐
Urological Conditions	☐	☐	Depression	☐	☐
Hearing Impairment	☐	☐	Anxiety	☐	☐
Multiple Sclerosis	☐	☐	PTSD	☐	☐
Neurological Disorders	☐	☐	Other Psychiatric Illness	☐	☐
Sleep Apnea	☐	☐	Cancer *	☐	☐
Erectile Dysfunction	☐	☐	Type:		
Other Sexual Dysfunction	☐	☐	*Please provide a copy of any cancer pathology reports		
Other	☐	☐			

Surgical History: (Please indicate Major Surgeries)

Type of Surgery Year Diagnosis/Reason

_____

_____

_____

_____

Health Tests and Procedures: (Please provide any of the following)

Date Last Completed Results (Normal/Abnormal)

PAP Smear (Women)_____

Mammogram (Women)_____

PSA, Prostate Exam (Men) _____

Colonoscopy _____

EKG _____

Bone Density _____

OB/GYN History:
Last Menstrual Period: _____
Age of first onset of period: _____
Duration of cycle if still menstruating:_____

Menstrual Cycle:
Heavy Periods: ☐ Yes ☐ No
Pain: ☐ Yes ☐ No
Spotting: ☐ Yes ☐ No
Irregular Periods: ☐ Yes ☐ No

Pregnancy:
If you are pregnant, how many weeks? _____

Have you done hormone replacement therapy in the past? ☐ Yes ☐ No
If so, list previous therapies: _____
_____

Have you done medically assisted weight loss in the past? ☐ Yes ☐ No
If so, list previous therapies: _____
_____

Do you follow a specific dietary intake or have dietary restrictions medically or culturally? ☐ Yes ☐ No
If so, please explain: _____
_____

Describe your regular exercise routine (frequency, intensity, duration/time): _____
_____
_____

By signing below, I acknowledge the above information is correct, and if indicated, I consent to allow Quince Orchard Medical Center to contact me as specified. Quince Orchard Medical Center will only send appointment reminders, review requests, and emergency messages by text or email and will not give out or sell this information to any marketing group.

_____
Signature of Patient, Parent, or Legal Guardian Date