



2329 Pacific Avenue, Forest Grove, OR 97116
Comprehensive Patient Health History Questionnaire

Name: _____ Date: _____ Age: _____
 Last First M.I.

Date of Birth: _____ Sex: F M

Address: _____
 Street/ P.O. Box City State Zip Code

Phone: Home #: _____ Work #: _____

Cell #: _____ E-mail: _____

Emergency Contact: _____
 Name Relation to patient Telephone number

Occupation: _____ Children: Y N How many? _____

Marital Status: Single: _____ Married _____ Divorced _____ Other _____

Do you live with: Spouse _____ Friends _____ Parents _____ Alone _____ Children _____

How did you hear about us? _____

Health care and preventive medicine are only possible when the Physician has complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything that you don't understand with a question mark.

When did you last go to a doctor's office, medical clinic, or hospital? What was the reason?

What are you most important health problems? List as many as you can in order of importance.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Signature: _____ Date: _____

SELF & FAMILY HISTORY

Check those applicable:	Father	Mother	Siblings	Spouse	Child
Age	_____	_____	_____	_____	_____
Health G=Good P=Poor	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Asthma, Hay fever, Hives	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____

For the following sections, please circle Yes or No

CHILDHOOD ILLNESSES

Scarlet Fever	Yes	No	Diphtheria	Yes	No	Rheumatic Fever	Yes	No
Mumps	Yes	No	Measles	Yes	No	German Measles	Yes	No

Other _____

HOSPITALIZATION AND SURGERY

What hospitalizations or surgeries have you had?

X-RAYS AND SPECIAL STUDIES

How many X-Rays, CAT scans or MRIs have you had? Please list and explain.

Electrocardiogram	Yes	No	Electroencephalogram	Yes	No
-------------------	-----	----	----------------------	-----	----

IMMUNIZATIONS

Polio	Yes	No	Pertussis	Yes	No
Diphtheria	Yes	No	Measles/Mumps/Rubella	Yes	No
Tetanus shot (not antitoxin)	Yes	No	Other	_____	

ALLERGIES

Do you have any allergies to foods, drugs or other allergens in your environment (cats, molds, dust)?
 Yes _____ No _____ If Yes, list and explain.

CURRENT MEDICATIONS (Circle the medications that you take):

Pain Relievers (Aspirin or Tylenol)	Cortisone (cream or pills)	Thyroid medications	Sleeping pills
Diet Pills/Appetite Suppressants	Antacids (Rolaids or Tums)	Laxatives	Tranquilizers

Please list prescription medications, over-the-counter drugs, vitamins or other supplements you are taking.

- 1) _____ 3) _____
 2) _____ 4) _____

REVIEW OF SYSTEMS

C = a current condition, N = a condition you have never had, P = a condition you have had in the past

Circle the correct response for the following:

GENERAL

Weight _____ Weight 1 year ago _____
 Maximum weight _____ When _____
 Height _____

Fatigue C P N

SKIN

Rashes C P N
 Eczema, hives C P N
 Acne, boils C P N
 Itching C P N
 Color change C P N
 Lumps C P N
 Night sweats C P N

HEAD

Headache C P N
 Head injury C P N

EYES

Impaired vision C P N
 Glasses or contacts C P N
 Eye pain C P N
 Tearing or dryness C P N
 Double vision C P N
 Glaucoma C P N
 Cataracts C P N

EARS

Impaired hearing C P N
 Ringing C P N
 Earache C P N
 Dizziness C P N

NOSE and SINUSES

Frequent colds C P N
 Nose bleeds C P N
 Stuffiness C P N
 Hay fever C P N
 Sinus problems C P N

MOUTH and THROAT

Frequent sore throat C P N
 Sore tongue C P N
 Gum problems C P N
 Hoarseness C P N
 Dental cavities C P N

NECK

Lumps C P N
 Swollen glands C P N
 Goiter C P N
 Pain or stiffness C P N

RESPIRATORY

Cough C P N
 Sputum C P N
 Spitting up blood C P N
 Wheezing C P N
 Asthma C P N
 Bronchitis C P N
 Pneumonia C P N
 Pleurisy C P N
 Emphysema C P N
 Difficulty breathing C P N
 Pain on breathing C P N
 Shortness of breath C P N
 At night C P N
 Lying down C P N
 Tuberculosis C P N

CARDIOVASCULAR

Heart disease C P N
 Angina C P N
 High blood pressure C P N
 Murmurs C P N
 Rheumatic fever C P N
 Chest pain C P N
 Swelling in ankles C P N
 Palpitations, fluttering C P N

GASTROINTESTINAL

Trouble swallowing C P N
 Heartburn C P N
 Change in thirst C P N
 Change in appetite C P N
 Nausea C P N
 Vomiting C P N
 Vomiting blood C P N
 Bowel movements
 How often? _____
 Is this a change? _____

Blood in stool C P N
 Belching or passing gas C P N
 Jaundice (yellow skin) C P N
 Liver disease C P N
 Gall bladder disease C P N
 Ulcer C P N
 Hemorrhoids C P N

URINARY

Pain on urination C P N
 Increased frequency C P N
 Frequency at night C P N
 Inability to hold urine C P N
 Frequent infections C P N
 Kidney stones C P N

FEMALE REPRODUCTIVE

Age menses began	_____		
Painful menses	C	P	N
Excessive flow	C	P	N
Birth control	Yes	No	
What type?	_____		
Number of pregnancies	_____		
Number of live births	_____		
Number of miscarriages	_____		
Number of abortions	_____		
Difficulty conceiving	Yes	No	
Menopausal symptoms	C	P	N
Are you sexually active?	Yes	No	
Sexual difficulties	C	P	N
Venereal disease	C	P	N
Do you self exam?	C	P	N
Lumps	C	P	N
Pain or tenderness	C	P	N
Nipple discharge	C	P	N
Bleeding between periods	C	P	N
Irregular cycles	C	P	N
Pain during intercourse	C	P	N
Length of cycle	_____		
Average number of days	_____		

MALE REPRODUCTIVE

Hernias	C	P	N
Testicular masses	C	P	N
Testicular pain	C	P	N
Are you sexually active	C	P	N
Sexual difficulties	C	P	N
Venereal disease	C	P	N
Discharge or sores	C	P	N

MUSCULOSKELETAL

Joint pain or stiffness	C	P	N
Arthritis	C	P	N
Broken bones	C	P	N
Muscle spasms or cramps	C	P	N
Weakness	C	P	N

PERIPHERAL VASCULAR

Deep leg pain	C	P	N
Cold hands/feet	C	P	N
Varicose veins	C	P	N
Thrombophlebitis	C	P	N

NEUROLOGIC

Fainting	C	P	N
Seizures	C	P	N
Paralysis	C	P	N
Muscle weakness	C	P	N
Numbness or tingling	C	P	N
Loss of memory	C	P	N

EMOTIONAL

Depression	C	P	N
Mood swings	C	P	N
Anxiety or nervousness	C	P	N
Tension	C	P	N

ENDOCRINE

Hypothyroid	C	P	N
Heat or cold intolerance	C	P	N
Excessive thirst	C	P	N
Excessive hunger	C	P	N

BLOOD

Anemia	C	P	N
Easy bleeding or bruising	C	P	N

HABITS

What are your main interests and hobbies?

Do you exercise? Yes No
 What type of exercise do you do?

How many days per week do you exercise?
 1 2 3 4 5 6 7

Do you eat three meals daily? Yes No
 Awaken rested? Yes No
 Sleep well? Yes No
 Average 6-8 hours sleep? Yes No
 Enjoy your work? Yes No
 Spend time outside? Yes No
 Watch television? Yes No
 How many hours per day? _____
 Read? Yes No
 How many hours per day? _____
 Take vacations? Yes No
 Have you been treated for
 drug dependence? Yes No
 Use recreational drugs? Yes No
 Use alcoholic beverages? Yes No
 Have you been treated for
 alcoholism? Yes No
 Use tobacco? Yes No

Terms and Conditions of Service: Forest Grove Health & Fitness

Consent for Treatment

Medical Consent: My care as a patient is directed by a licensed supervising physician. I consent to services rendered and provided to me under the instruction of supervising staff physicians.

Consent for Release of Information

Release of Information to Physician, Referring Physician, Insurers and Professional Review

Organization: I authorize release of medical and related information, including alcohol, drug abuse and mental health records obtained in the course of diagnosis and treatment to the insured's insurance carrier(s), agencies and their intermediaries or carriers, if applicable, for the purpose of obtaining care, treatment or payment for services provided or to be provided. This information may be released via first class mail, facsimile or certified courier, as applicable. Authorization may be withdrawn at any time by written notification.

Social Security numbers: Forest Grove Health & Fitness collects administrative and nonmedical patient data including social security numbers for the purpose of patient identification, compliance with federal and state agency reporting requirements, billing to insurance carriers and collection needs. Disclosure of the social security number information is voluntary. I have provided this information to and authorize Forest Grove Health & Fitness to use this information for the purpose stated above.

Statement of Financial Responsibility.

Financial Agreement: The undersigned, jointly and severally, in consideration of services to be rendered to patient, agree to pay each provider of service, in accordance with their regular rates and terms, for the services rendered. The undersigned further agrees to pay reasonable attorney fees and expenses incurred in collecting all sums not paid when due, whether or not litigation is actually commenced, as well as all attorney fees and costs on appeal. The undersigned assigns to each provided of service all insurance benefits available for their professional and clinic services rendered. The assignment is nonrevocable, and the undersigned authorizes carrier of said benefits to make payment directly to Forest Grove Health & Fitness or other related billing services. Payments received from insurers will apply to the patient's account balance obligation. The undersigned agrees to promptly pay any charges that are not immediately (within 30 days) covered by insurance.

I agree that the above consents, authorizations to release information and financial agreement apply to the medical services provided for two years from the date shown below.

I have read, fully understand and agree to the above statements.

Patient (18 years or older)

Date

Parent, Guardian, Responsible Party, Legal Representative

Date

Witness

Date