Office: 503.885.7770

Fax: 503.885.7771

IMPORTANT: Please fill in as completely as possible.

Name:_____Email:_____

PATIENT MEDICAL INFORMATION

Do you take any medications? ☐ Yes ☐ No If yes, please list: _____
Blood Thinners? ☐ Yes ☐ No
Are you allergic to any drugs? ☐ Yes ☐ No If yes, please list: _____
Are you on a pain contract with another Dr. ☐ Yes ☐ No If yes, Dr. Name: _____
What is your current Weight? _____ Height? _____

PAST MEDICAL HISTORY

Last Physical Exam: _____
Have you had any surgeries? ☐ Yes ☐ No
Please list: _____
_____
Have you had any injuries? ☐ Yes ☐ No
Please list: _____
_____

Diabetes	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No

Please list any past or present illnesses: _____
_____
Have you ever been diagnosed with MRSA, Hepatitis or HIV? ☐ Yes ☐ No
Please list: _____

REVIEW OF SYMPTOMS Do you currently experience:

Night Sweats	☐ Yes	☐ No	Weight Gain	☐ Yes	☐ No
Rashes	☐ Yes	☐ No	Weight Loss	☐ Yes	☐ No
Stiffness	☐ Yes	☐ No	Chest pain	☐ Yes	☐ No
Numbness	☐ Yes	☐ No	Fainting Spells	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No	Ringing in ears	☐ Yes	☐ No
Muscle pain	☐ Yes	☐ No	Stomach pain	☐ Yes	☐ No
Irregular heart rate	☐ Yes	☐ No	Excessive thirst	☐ Yes	☐ No
Fever and chills	☐ Yes	☐ No	Excessive hunger	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Excessive need to go to the bathroom	☐ Yes	☐ No
Weakness	☐ Yes	☐ No			

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No How many packs per day? _____
Are you married? ☐ Yes ☐ No How many children? _____Ages: _____
What are your hobbies: _____

FAMILY HISTORY

Do you or family members have:

Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Bad reaction to Anesthesia	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	Other Disease – Please list	☐ Yes	☐ No