

# Santiam Medical Associates Patient Information

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Pharmacy of Choice: \_\_\_\_\_

**Office Use Only**

Updated \_\_\_\_\_

\_\_\_\_ No Change per Pt.

\_\_\_\_ See Changes per Pt.

What town do you live in? \_\_\_\_\_

Who else lives with you presently? \_\_\_\_\_

Are you \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Other

Number of living children \_\_\_\_\_

Are you \_\_\_ Employed \_\_\_ Unemployed \_\_\_ Retired \_\_\_ Full time homemaker

\_\_\_ Disabled Why disabled? \_\_\_\_\_

Occupation \_\_\_\_\_ Any occupational hazards? \_\_\_\_\_

## Have you had the following surgeries?

Yes No Appendix removed Yes No Abdominal surgery \_\_\_\_\_

Yes No Gall bladder removed Yes No Knee surgery \_\_\_\_\_

Yes No Hysterectomy or ovaries removed Yes No Carpal tunnel \_\_\_\_\_

Yes No Heart surgery (CABG) Yes No Cataract surgery \_\_\_\_\_

Yes No C-Section Yes No Tonsils and/or adenoids \_\_\_\_\_

List any other surgeries: \_\_\_\_\_

## Allergies:

Yes No Latex \_\_\_\_\_

Yes No Food \_\_\_\_\_

Yes No Medication \_\_\_\_\_

Current Medications and Dosage: (Include birth control, vitamins and natural medicines) \_\_\_\_\_

## Family History of Illness: (Please circle yes or no. If yes, note which family member.)

Yes No Bleeding Disorders Yes No Asthma \_\_\_\_\_

Yes No Heart Attack Yes No Seizures \_\_\_\_\_

Yes No Serious reaction to anesthesia Yes No Breast Cancer \_\_\_\_\_

Yes No Diabetes Yes No Ovarian Cancer \_\_\_\_\_

Yes No Stroke Yes No Uterine Cancer \_\_\_\_\_

Yes No High blood pressure Yes No Prostate Cancer \_\_\_\_\_

Yes No Alzheimer's Yes No Rectal/Colon Cancer \_\_\_\_\_

Yes No Osteoporosis or hip fractures Yes No Melanoma (malignant mole) \_\_\_\_\_

Other \_\_\_\_\_

## Habits: (Answer yes or no to the following questions. If yes, please explain.)

Yes No Do you smoke or chew tobacco and if so, how much per day/month/year? \_\_\_\_\_

Yes No Have you ever smoked or used tobacco and if so, when did you quit? \_\_\_\_\_

Yes No Do you drink alcohol and if so, how much per day/month/year? \_\_\_\_\_

Yes No Did you ever drink alcohol and if so, when did you quit? \_\_\_\_\_

Yes No Have you used drugs in the past? \_\_\_\_\_

Yes No Do you exercise? How often? \_\_\_\_\_

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**Past Medical History:**

(You must circle yes or no to every question below. Add any that are not listed if necessary)

- Yes No High blood pressure
- Yes No High cholesterol
- Yes No Heart irregularity
- Yes No Heart valve disease
- Yes No Angina/Heart pain
- Yes No Heart failure
- Yes No Heart attack
- Yes No Pacemaker
- Yes No Defibrillator
- Yes No Rheumatic fever
- Yes No Thyroid problem
- Yes No Gout
- Yes No Arthritis
- Yes No Hiatal hernia
- Yes No Stomach ulcer
- Yes No Pancreatitis
- Yes No Cancer
- Yes No Radiation therapy
- Yes No Diabetes
- Yes No Asthma
- Yes No Emphysema
- Yes No Tuberculosis
- Yes No Blood clot in legs/  
phlebitis
- Yes No Blood clots in lung/  
embolism
- Yes No Stroke
- Yes No Liver disease
- Yes No Hepatitis
- Yes No Cirrhosis
- Yes No Kidney disease
- Yes No Anemia
- Yes No Glaucoma
- Yes No Colon polyps
- Yes No Colitis
- Yes No Diverticular disease
- Yes No Gallstones
- Yes No Steroid therapy
- Yes No Sleep apnea
- Yes No COPD

**Have you ever received:**

- Yes No Childhood immunizations
- Yes No Hepatitis vaccine
- Yes No Pneumococcal
- Yes No Flu Vaccine
- Yes No Tetanus toxoid
- Yes No Shingles vaccine

**Do you have a:**

- Yes No Living Will
- Yes No Durable power of attorney

**Review of Systems:**

(Please circle yes or no if in the past 3 months you have had any of the following)

**General:**

- Yes No Fever
- Yes No Night sweats
- Yes No Poor appetite
- Yes No Weight loss
- Yes No Injury to \_\_\_\_\_

**Neurological:**

- Yes No Unusual headaches
- Yes No Seizures
- Yes No Epilepsy
- Yes No Paralysis

**Eyes, Ears, Nose & Throat:**

- Yes No Worsening vision
- Yes No Temporary loss of vision
- Yes No Double vision
- Yes No Hearing difficulties
- Yes No Earache/drainage
- Yes No Nose bleeds
- Yes No Hoarseness
- Yes No Sores in mouth
- Yes No Do you use CPAP?

**Skin:**

- Yes No Changing mole
- Yes No Non-healing sores

**Breasts:**

- Yes No Lump
- Yes No Bloody nipple discharge
- Yes No Breastfeeding

**Blood & Lymphatic:**

- Yes No Easy bruising
- Yes No Lump in neck
- Yes No Lump in armpit

**Bone & Joint:**

- Yes No Bone pain
- Yes No Joint swelling/pain

**Genital:**

- Yes No Swollen testes
- Yes No Vaginal bleeding/discharge
- Yes No Painful Intercourse
- Yes No Pregnant

**Heart & Lung:**

- Yes No Shortness of breath (SOB)
- Yes No SOB with exertion
- Yes No SOB at rest

- Yes No SOB suddenly at night
- Yes No Chest pain/tightness
- Yes No Racing of heart/skipping  
beats
- Yes No Swelling ankles
- Yes No Frequent coughing
- Yes No Coughing up phlegm
- Yes No Wheezing
- Yes No Cramping of legs
- Yes No Cramping with walking
- Yes No Cramping of legs at night

**Digestive:**

- Yes No Heartburn
- Yes No Regurgitation of sour  
fluids in throat
- Yes No Difficulty swallowing
- Yes No Excessive belching
- Yes No Nausea
- Yes No Vomiting
- Yes No Gassiness in belly
- Yes No Bloating of belly
- Yes No Excessive flatus (gas)
- Yes No Pain in belly
- Yes No Antacid use
- Yes No Blood in stool (black or  
red)
- Yes No Constipation
- Yes No Laxative use
- Yes No Diarrhea
- Yes No Anal/Rectal pain
- Yes No Jaundice (yellow eyes)

**Urinary:**

- Yes No Pain/burning when  
urinating
- Yes No Weak stream
- Yes No Urinating at night 3 times  
or more

**Psychiatric:**

- Yes No History of depression
- Yes No History of anxiety
- Yes No History of Bipolar disorder

**Health Screenings:**

(If yes, give date of most recent.)

- Yes No Colonoscopy \_\_\_\_\_
- Yes No Mammogram \_\_\_\_\_
- Yes No Bone scan (Dexa scan) \_\_\_\_\_

Last physical \_\_\_\_\_

Last PSA (males) \_\_\_\_\_

Last PAP smear (females) \_\_\_\_\_