MEDNORTHWEST

Welcome! This form helps us to meet your medical needs and to provide the best service to you. If you have any questions or need assistance, please ask us.

GENERAL PATIENT INFORMATION

Name: _____ Home Phone: _____

Date of Birth: _____ Gender: ☐ Female ☐ Male Cell Phone: _____

Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ E-mail Occupation: _____

EMERGENCY CONTACT INFORMATION

Contact #1 Name: _____ Contact #2 Name: _____

Relationship to You: _____ Relationship to You: _____

Contact #1 Phone: _____ Contact #2 Phone: _____

INSURANCE ASSIGNMENT AND RELEASE

Please make sure we have a copy of your insurance card.

I hereby authorize payment directly to Daniel S. Frank, MD, PLLC for all insurance benefits otherwise payable to me for services rendered. I am responsible for all charges not covered by insurance.

Signature: _____ Date: _____

What brings you into the office today? _____

This form is long! Please feel free to have the doctor or medical staff help you to complete it if you need any assistance at all.

CURRENT HEALTH SUMMARY

Please list any current medical issues, the date you first noticed the issue, and the name and specialty of the physician who treated you (if any):

Current Medical Concerns	Date of Onset	Physician's Name	Specialty

List any current medications, including over-the-counter drugs, aspirin, vitamins and herbal preparations. ☐ I am on no medications.

Medication Name	Pill Size	How Taken	Medication Name	Pill Size	How Taken

ALLERGY INFORMATION

List any allergies you have in the table below. ☐ I have no allergies of any kind.

Food, Medication, or Insect	Reaction		Food, Medication, or Insect	Reaction

Additionally, please check if you are allergic to any of the following: ☐ Shellfish ☐ Contrast (Dye) ☐ Latex

VACCINATION HISTORY

Vaccine	Date		Vaccine	Date
Tetanus			Hepatitis A	
Flu Shot			Hepatitis B	
Pneumovax (pneumonia)			Gardasil (HPV)	
Prevnar (PVC13)			Other (?)	
Zostavax (shingles)			Other (?)	

SURGICAL HISTORY

Surgery or Procedure	Date	Name of Surgeon	Outcome

HEALTH MAINTENANCE

Please enter the date of your last:	Date		Female patients only:	Date
Colonoscopy			When was your last mammogram?	
Bone density scan (DEXA)			When was your last pap smear?	
Treadmill test (stress test)			Have you ever had an abnormal pap?	☐ Yes ☐ No
Coronary calcium score			If yes, when was it?	
Annual exam			Did you undergo treatment? (please explain)	
Ultrasound test for aortic aneurysm				
PSA (male patients only)				

FAMILY MEDICAL HISTORY

A "close relative" is a brother, sister, mother, father, or child. However, please consider any other relatives where you feel it may be helpful.

Do you have a **family history** of heart attacks, stents, or bypass surgery? ☐ Yes ☐ No

If yes, please list relative(s), type of heart disease, and the age when symptoms started.

Have any of your **close relatives** had a history of stroke? ☐ Yes ☐ No

If yes, please list the relative(s), and the age at which the stroke first occurred.

Do you have a **family history** of colon polyps or colon cancer? ☐ Yes ☐ No

If yes, please list the relative(s), type of colon issue, and the age when symptoms first appeared.

Do you have a **family history** of diabetes? ☐ Yes ☐ No

If yes, please list the relative(s) and the age at which diabetes first developed.

Has anyone in your **family** had Alzheimer's Disease? ☐ Yes ☐ No

If yes, please list the relative(s) and the age at which memory problems first occurred.

Is there a **family history** of mental health problems that you feel is relevant? ☐ Yes ☐ No

If yes, please list the relative(s) and describe the type of problem.

Did you have a **close relative** with prostate cancer? *(male patients only)* ☐ Yes ☐ No

If yes, please list the relative(s) and the age at which it first occurred.

Do you have a **close relative** with osteoporosis or fractures? ☐ Yes ☐ No

If yes, please list the family member(s), the type of fracture, and the age at which it first occurred.

Any **close relatives** with a history of breast cancer or ovarian cancer? ☐ Yes ☐ No

If yes, please list the family member(s), the type of cancer, and the age at which it first occurred.

Have any **relatives** been tested for the BRCA-1 or BRCA-2 genes? ☐ Yes ☐ No

If yes, what were the results?

If you have other **family** health history that you feel is relevant describe the type of disease and the age at which symptoms first occurred.

REVIEW OF SYSTEMS

In the last six months, have you experienced any of the following?

Constitutional

- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ Unexplained fever
- ☐ None of these

Eyes

- ☐ Difficulty with vision
- ☐ History of eye surgery
- ☐ Glaucoma
- ☐ None of these

Ears, Nose, and Throat

- ☐ Sleepy during the day
- ☐ Loud snoring at night
- ☐ Sleep Apnea
- ☐ Hearing loss
- ☐ Frequent sinus or ear infections
- ☐ None of these

Heart

- ☐ Born with a heart defect
- ☐ Have a pacemaker
- ☐ Heart murmur
- ☐ Take antibiotics before dental work
- ☐ Heart valve problems
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Stroke or TIA
- ☐ Abnormal Heart Rhythm
- ☐ None of these

Genitourinary (Men)

- ☐ Slow urine stream
- ☐ Up more than once per night to urinate
- ☐ Blood in the urine
- ☐ Trouble getting or maintaining erections
- ☐ Lump or mass in the testicles
- ☐ Hernia
- ☐ Any sexual concerns
- ☐ None of these

Genitourinary (Women)

- How many children have you had?_____
- ☐ Leakage of urine?
- ☐ Heavy or irregular periods
- ☐ Vaginal pain, soreness, or dryness
- ☐ Blood in urine
- ☐ Hernia
- ☐ Any sexual concerns
- ☐ None of these
- ☐ I had a hysterectomy
- ...if so do you still have your ovaries? _____

Allergic or Immunologic

- ☐ Seasonal allergies
- ☐ Had chickenpox as a child
- ☐ None of these

Musculoskeletal

- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Other joint pains
- ☐ History of fractures. If so, what kind?

  _____
- ☐ None of these

Respiratory

- ☐ Asthma or wheezing
- ☐ Emphysema (COPD)
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ None of these

Neurological

- ☐ Headaches
- ☐ Trouble with short term memory
- ☐ Seizures
- ☐ Numbness in the feet (neuropathy)
- ☐ History of ADD or trouble with focusing?
- ☐ None of these

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Trouble sleeping
- ☐ Panic attacks
- ☐ Specific fears (driving, elevators, etc)
- ☐ Thoughts of hurting or killing yourself
- ☐ History of substance abuse
- ☐ Prior suicide attempt
- ☐ Psychiatric hospitalization
- ☐ Bipolar Illness
- ☐ None of these

Endocrine

- ☐ Thyroid problems
- ☐ Severe menopausal symptoms
- ☐ Diabetes
- ☐ Low testosterone
- ☐ None of these

REVIEW OF SYSTEMS *(continued from the previous page)*

In the last six months, have you experienced any of the following?

Hematologic

- ☐ Easy bleeding after surgery or dental work (ever in your life)
- ☐ History of anemia (low blood count)
- ☐ Iron deficiency
- ☐ None of these

Skin/Breast

- ☐ Breast lump or mass
- ☐ Unusual mole
- ☐ Skin cancer
- ☐ None of these

Oncology (Cancer)

- ☐ History of any type of cancer? If so, what kind?_____

  _____

Gastrointestinal

- ☐ Hepatitis
- ☐ Other liver disease
- ☐ Blood in stool
- ☐ Heartburn
- ☐ Ulcer
- ☐ Unexplained abdominal pain
- ☐ Trouble swallowing solids or liquids
- ☐ Sensitivity to milk products
- ☐ Wheat allergy
- ☐ Diverticulitis
- ☐ Polyps
- ☐ None of these

TOBACCO, ALCOHOL, CAFFEINE, AND DRUG USE HISTORY

Have you ever smoked? ☐ Yes ☐ No	_____ # packs / day _____ # of years	When did you quit? _____
Do you chew tobacco? ☐ Yes ☐ No		
How many alcoholic drinks do you have in a typical week?	_____ # of drinks	
Did you drink more heavily in the past? ☐ Yes ☐ No		
Has anyone ever suggested that you cut down your drinking? ☐ Yes ☐ No		
How many cups of coffee do you drink daily?	_____ # of drinks	
Any recreational drug use (marijuana, cocaine, and so forth)? ☐ Yes ☐ No		
If yes, please describe:		

PERSONAL SAFETY

Please check all that apply:	
☐ I have a smoke detector in my home.	☐ I wear a seat belt.
☐ I have a carbon monoxide detector at home.	☐ I have a living will.
☐ I use a cell phone while driving. *(This is equally dangerous with or without a headset.)*	☐ I have a history of multiple falls
	☐ I feel threatened by or afraid of someone close to me.
☐ I keep firearms in my house. *(If the answer is yes, we urge you to keep them locked or inside a locked compartment.)*	☐ I have a durable power of attorney for health care. (That person is_____.)

OTHER HEALTH INFORMATION

I might benefit from some help with...	
☐ Drinking a bit more than I should.	☐ Being too quick to anger.
☐ Use of substances.	☐ Troubled relationships.
☐ Gambling.	☐ Getting more exercise.
☐ Improving my mental health.	☐ Life stress.
☐ Weight loss.	☐ Past issues or bad experiences that still bother me.
☐ Loneliness or social isolation.	☐ Other:

Do you exercise on a regular basis? ☐ Yes ☐ No If so, what activities and how many times per week?

Do you follow any kind of special diet? ☐ Yes ☐ No If so, what?

Are there any other medical concerns or questions you would like addressed?

Anything else we should know to provide the best care and service to you?

NOTES