Providence Medical Group-Hood River
Internal Medicine
1108 June St.
Hood River, OR 97031
541-387-6125 | fax 541-387-6321

Appointment date _______________

Appointment time _______________

Welcome to the Providence Medical Group-Hood River Internal Medicine. We welcome you as a patient and thank you for choosing us to participate in your health care.

For your first appointment, please arrive **15 minutes prior to your scheduled appointment to complete registration process.** Additionally, we ask that you bring all medications you are currently taking, including supplements and over-the-counter medications, in the original bottles, so that they charted correctly upon your initial visit. **Please request the last six months of chart notes from your current primary care physician and the last two years of specialty care including labs and X-rays**.

Please see the enclosed information regarding your first appointment.

We request that you refrain from wearing perfumes or colognes, as we see many patients who are susceptible to allergic reactions to scents.

Please bring the following to your appointment:

- Photo ID
- Medical insurance card
- Completed enclosed forms
- All current medications, in the original bottles

If you have any questions, please call us at 541-387-6125.

We look forward to seeing you soon.

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History form:
Please fill out your medical history as completely as possible.

Medications:
Please bring in all your current medications in the original bottles.

Record release form:
If you are transferring from another care provider, please request your records be transferred to your new doctor before to your appointment. You will find this form, Authorization for Release of Medical Records, in your packet.

If you need a copy of your lab results, you can sign a two-year release of records in your physician's office.

Cancellation policy:
We ask that you contact our office at least 24 hours before to your scheduled appointment if you need to cancel or reschedule. This allows appointments for other patients.

Before your appointments:
Please arrive 15 minutes before your appointment to allow time for registration. Remember to transfer your medical records from your previous provider.

Notice:
If you arrive more than 10 minutes past your scheduled appointment time, you may be asked to reschedule your appointment.

Billing Questions: 541-387-8219 or 877-215-7833

Initial Health Questionnaire

Patient Name Email	Age	Sex	Date of Birth	Marital Status
		❑ M ❑F	/ /	❑ M ❑ S ❑ W ❑ Div ❑ Sep

DO YOU HAVE RECENT OR RECURRENT PROBLEMS WITH:

HEADACHE	❑ Yes	❑ No	SWELLING OF YOUR LEGS	❑ Yes	❑ No
FAINTING SPELLS	❑ Yes	❑ No	HIGH CHOLESTEROL	❑ Yes	❑ No
EXCESSIVE DIZZINESS	❑ Yes	❑ No	LEG CRAMPS WITH WALKING	❑ Yes	❑ No
NUMBNESS OR TINGLING IN HANDS OR FEET	❑ Yes	❑ No	LEG CRAMPS AT NIGHT	❑ Yes	❑ No
MOMENTARY LOSS OF VISION IN ONE EYE	❑ Yes	❑ No	ABDOMINAL PAIN OR CRAMPING	❑ Yes	❑ No
DOUBLE VISION	❑ Yes	❑ No	HEARTBURN	❑ Yes	❑ No
DECREASING MEMORY	❑ Yes	❑ No	NAUSEA OR VOMITING	❑ Yes	❑ No
WEAKNESS SPECIFICALLY ON ONE SIDE OF YOUR BODY	❑ Yes	❑ No	BLACK COLORED STOOL	❑ Yes	❑ No
			RECTAL BLEEDING	❑ Yes	❑ No
SLURRED SPEECH	❑ Yes	❑ No	DIARRHEA	❑ Yes	❑ No
HEAD TRAUMA	❑ Yes	❑ No	CONSTIPATION	❑ Yes	❑ No
TREMOR OR HAND SHAKING	❑ Yes	❑ No	CHANGE IN SIZE OR SHAPE OF STOOL	❑ Yes	❑ No
DEPRESSION	❑ Yes	❑ No	PAIN OR BURNING ON URINATION	❑ Yes	❑ No
FREQUENT FALLS	❑ Yes	❑ No	DIFFICULTY STARTING URINATION	❑ Yes	❑ No
RINGING IN EARS	❑ Yes	❑ No	DO YOU GET UP AT NIGHT TO URINATE	❑ Yes	❑ No
DECREASE IN HEARING	❑ Yes	❑ No	HOW MANY TIMES?		
RECURRENT NOSEBLEEDS	❑ Yes	❑ No	ANY PENILE DISCHARGE	❑ Yes	❑ No
SINUS TROUBLE	❑ Yes	❑ No	BLOOD IN URINE	❑ Yes	❑ No
PERSISTENT HOARSNESS	❑ Yes	❑ No	LOSE URINE WITH COUGHING OR SNEEZING	❑ Yes	❑ No
DIFFICULTY OR PAIN ON SWALLOWING	❑ Yes	❑ No	LOSE URINE AT OTHER TIMES	❑ Yes	❑ No
RECURRENT MOUTH SORES	❑ Yes	❑ No	DECREASE IN THE FORCE OF URINE STREAM	❑ Yes	❑ No
EXCESSIVE BLEEDING W/BRUSHING	❑ Yes	❑ No	FREQUENT URINARY TRACT INFECTIONS	❑ Yes	❑ No
PERSISTENTLY ENLARGED GLANDS	❑ Yes	❑ No	BACK PAIN	❑ Yes	❑ No
CHEST PAIN	❑ Yes	❑ No	JOINT PAINS	❑ Yes	❑ No
COUGH UP BLOOD	❑ Yes	❑ No	HEAT OR REDNESS OF ANY JOINT	❑ Yes	❑ No
PAIN IN ARMS	❑ Yes	❑ No	ARTHRITIS	❑ Yes	❑ No
SOAKING NIGHT SWEATS	❑ Yes	❑ No	WHAT DID YOU WEIGH 1 YEAR AGO?		
CHRONIC OR FREQUENT COUGH	❑ Yes	❑ No	WHAT DID YOU WEIGH 5 YEARS AGO?		
WAKE UP NIGHTS SHORT OF BREATH	❑ Yes	❑ No	EXCESSIVE FATIGUE WITHOUT REASON	❑ Yes	❑ No
HOW MANY PILLOWS DO YOU USE?			BRUISE EASILY WITHOUT HITTING	❑ Yes	❑ No
SHORTNESS OF BREATH ON:			INTOLERANCE TO HOT WEATHER	❑ Yes	❑ No
WALKING SEVERAL BLOCKS	❑ Yes	❑ No	INTOLERANCE TO COLD WEATHER	❑ Yes	❑ No
ONE FLIGHT OF STAIRS	❑ Yes	❑ No	CHANGE IN HAIR TEXTURE	❑ Yes	❑ No
ON LYING DOWN	❑ Yes	❑ No	LOSS OF HAIR	❑ Yes	❑ No
PALPITATIONS OR FLUTTERING OF HEART	❑ Yes	❑ No	IMPOTENCE	❑ Yes	❑ No

ARE YOU EXPERIENCING PAIN RIGHT NOW?	❑ Yes ❑ No	**HOW LONG HAVE YOU BEEN EXPERIENCING THIS PAIN?**	❑ 6 months or less ❑ More than 6 months
IF SO, PLEASE RATE ON A SCALE OF 1 TO 10 (1 BEING THE LOWEST, 10 THE HIGHEST)	________________	**How would you describe your health?**	❑ EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR
Do you have a rubber (latex) allergy?	❑ **Yes** ❑ **No**		

NAME:		DOB:	

PLEASE LIST ALL CONDITIONS THAT YOU SEE A PHYSICIAN FOR AND PHYSICIAN IN CHARGE

	YEAR OF ONSET	ATTENDING PHYSICIAN

PLEASE LIST ALL OPERATIONS WITH YEAR PERFORMED AND SURGEON

PLEASE LIST ALL MEDICATIONS, DOSES AND HOW OFTEN YOU TAKE THEM, INCLUDING HERBAL & NATUROPATHIC MEDICATIONS:

PLEASE LIST ALL MEDICATION ALLERGIES AND THEIR REACTIONS

Do you or have you ever used Tobacco?	What	How Much	How Long	Year Quit
Do you use Alcohol?	What	How Much	How Long	Year Quit
Do you use Caffeine?	What	How Much	How Long	Year Quit
Do you use injectable Drugs?	What	How Much	How Long	Year Quit

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE AT DEATH	CAUSE
FATHER				
MOTHER				

NUMBER OF BROTHERS	NUMBER LIVING	NUMBER DECEASED	CAUSE
NUMBER OF SISTERS	NUMBER LIVING	NUMBER DECEASED	CAUSE
NUMBER OF CHILDREN	NUMBER LIVING	NUMBER DECEASED	AGES OF EACH

ILLNESSES OF CHILDREN

Do you know of any blood relative who has or had (check and give relationship)

CANCER ______ Heart Disease ______ High Blood Pressure ______ DIABETES ______

STROKE ______ High Cholesterol ______

Others Involved in Your Health Care

This office requires a signed release to give any information regarding appointments, test results, health status, etc. to others. Anyone not listed on this form will not be given any information without a separate, specific release signed by the patient or legal representative.

Please note: Patients are no longer considered minors after age 17. If a patient over the age of 17 wishes to release information to a parent or guardian, they must include the name and relationship of that person on this form. Information will not automatically be given because a patient resides with his or her parent(s) or guardian(s).

Medical information is to be released to:

Name	Relationship	Phone number

______________________________ ______________________

Patient name [Print] **Date of birth**

______________________________ ______________________

Authorized signature **Today's date**

______________________________ ______________________

Legal representative if not patient [Print] **Relationship**

MR# ______________________

Authorization for Release of Medical Records

Patient's Name: ______________________________

First *Middle* *Last*

Date of Birth: ____/____/____ **Social Security Number:** ______________________________

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION		
FROM:	Name (Medical Provider holding records): ______________________ Address: ______________________	
TO:	Name: Address:	Phone # Fax #

The purpose of the release is: ❑ Diagnostic Evaluation ❑ Reimbursement ☑ Follow-Up Care ❑ Legal ❑ Other

The following information may be released: ☑ Clinical notes (Re: ______________________)

☑ Laboratory Reports (LAST 2 YEARS) ☑ Immunization Records ☑ Medication Records ☑ X-Ray Reports

☑ Other: EKG'S, PATHOLOGY REPORTS, SPECIAL STUDIES, SPECIALISTS' CONSULTS, HOSPITAL RECORDS INCLUDING ER VISITS, ADMITS, H&P'S, IN PT. CONSULTS, SURGERY/PROCEDURE REPORTS, AND DISCHARGE SUMMARIES (LAST six MONTHS ONLY)

Information may be released for dates of service from SEE ABOVE through SEE ABOVE

This authorization expires six months from the date signed or: ______________________ (specified expiration date)

I have read the above and fully understand its contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

______________________ (Signature of patient or representative)

______________________ Relationship (if signed by representative)

______________________ Date Signed

______________________ Witness (optional)

Driver's License/Identification ______________________

I do ____/do not ____ specifically consent to transmission of my medical records via a facsimile (fax) machine. Signature ______________ Date	I recognize that the information disclosed may contain drug/alcohol information that is protected by Federal and State law. I specifically consent to disclosure of such information Signature ______________ Date
I recognize that the information disclosed may contain mental health information that is protected by Federal and State Law. I specifically consent to disclosure of such information Signature ______________ Date	I recognize that the information disclosed may contain information regarding sexually transmitted diseases or HIV / AIDS testing information. I specifically consent to disclosure of such information Signature ______________ Date

This authorization may be revoked at any time unless prior action has been taken as a result of this form. Records obtained as authorized by this consent for information release will be maintained in accordance with Federal confidentiality regulations (Title 42 of the Federal Register) which prohibits re-disclosure.

Medical Record # ______________________