PROVIDENCE
Medical Group

Welcome to Providence Medical Group

Thank you for choosing Providence Medical Group for your health care needs. Here is information that may help you as a new patient:

Insurance card and co-pay	• Please bring your insurance card to each visit. • We will ask you to pay your co-pay at each visit.
Medication refills	• You and your provider will review the medication you take at your first visit. • Call your pharmacy for all your medication refills. • If you use a mail order pharmacy, bring us your paperwork. We will fill it out and get it back to you within 3 days. Remember to ask your mail order pharmacy for a refill 2 weeks before you need one. • We do not refill medication or prescribe controlled medications at the walk-in clinic.
Test results	• We will call you with test results or send them to you in the mail. • We have an online patient portal called **MyChart**. We will help you sign up for MyChart at your first visit. After you sign up, you will be able to see your test results and health records on MyChart.
Same day visits	• **Call your clinic if you need a same-day visit.** • Other same-day visit choices are: o Urgent Care **PMG Medford Medical Clinic** **70 Bower Drive, Medford, OR, 97501** **Monday through Friday: 8 am – 7 pm** **Saturday and Sunday: 9 am – 3 pm** o Walk-in Clinic **PMG Central Point** **870 S. Front St, Suite 200, Central Point, OR 97502** **Monday through Friday: 8 am – 8 pm** **Saturday: 9 am – 5 pm**

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Please fill out this health history form as best you can:

Name: ____

Date of birth: ____

Prior provider: _______________________________________

Please check the **conditions** you have: ☐ **No conditions**

☐ Anemia	☐ Depression	☐ Meningitis
☐ Problems with anesthesia	☐ Diabetes	☐ Heart attack
☐ Anxiety	☐ Emphysema	☐ Nerve or muscle problems
☐ Arthritis	☐ Allergies, seasonal	☐ Osteoporosis
☐ Asthma	☐ GERD or heartburn	☐ Seizures
☐ Blood transfusion	☐ Heart murmur	☐ Sickle cell anemia
☐ Cancer: __________________	☐ Hepatitis A, B, C	☐ Stroke
☐ Cataracts	☐ HIV or AIDS	☐ Substance abuse
☐ Heart failure	☐ High cholesterol	☐ Thyroid disease
☐ Clotting disorder	☐ High blood pressure	☐ Tuberculosis or TB
☐ COPD	☐ Kidney problems	☐ Other: _____________

Please check the **surgeries** you have had and write the **date** you had it: ☐ **No surgery**

☐ Appendix	☐ Biopsy of: ________________	☐ Tonsils
☐ Gallbladder	☐ Joint replacement of:	☐ Other: ______________
☐ Hernia	________________________	☐ Other: ______________
☐ Hysterectomy	☐ Mastectomy	☐ Other: ______________
Reason: __________________	☐ Ovaries removed	☐ Other: ______________

Please let us know of **allergies** you have: ______________________________ ☐ **No allergies**

Please list the **medications, vitamins,** and **supplements** you take:

Name	Dose	How do you take the medications?
____________________	___________	____
____________________	___________	____
____________________	___________	____
____________________	___________	____
____________________	___________	____

Name of the **pharmacy** you use: ____________________________________

☐ I would like a 90-day prescription

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Name: ____

Date of birth: ____

Do you have an **Advance Directive**?

☐ Yes, please bring a copy with you to your appointment.

☐ No

Do you have a **POLST**?

☐ Yes, please bring a copy with you to your appointment.

☐ No

Let us know how **you are feeling today**:

Over the past 2 weeks, how often have you been bothered by:	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

P H Q 9

Do you use or have you ever used **tobacco or drugs**? ☐ Yes ☐ No

- If you no longer use tobacco, what year did you quit? _______
- How many packs of cigarettes per day did/do you smoke? ________
- How many cans per day did/do you chew? _________
- If you currently smoke and/or chew, how do you feel about quitting? ________
- Are you currently using drugs? ________
- Have you abused drugs in your past? _______
- How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons? ☐ None or ☐ 1 or more

D A S T

- For **men**: How many times in the past year have you had 5 or more drinks in a day? ☐None or☐ 1 or more
- For **women**: How many times in the past year have you had 4 or more drinks in a day? ☐None or ☐ 1 or more

A U D I T

Please let us know about your **preventive health services:**

- What was the date of your last colonoscopy? __________ Where was it done? ______________________
- What was the date of your last eye exam? _________ Who is your eye care provider? ____________
- Please let us know the names of other providers or doctors who are part of your health care:

  Name: ____ Specialty: __________________________

  Name: ____ Specialty: __________________________

  Name: ____ Specialty: __________________________
- For **men** only: what was the date of your last:
  - Prostate exam and PSA testing: _______________________________
- For **women** only: what was the date of your last:
  - Menstrual period: __________
  - PAP Smear: __________
  - Mammogram: __________
  - Bone Density Study: __________

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Review of Systems

Name: ____

Date of birth: _______________________________________

Please let us know how you are **feeling** today: ☐ **No symptoms below**

Constitutional
☐ chills
☐ fatigue
☐ fever
☐ sweats
☐ weakness
☐ weight loss / gain

Skin
☐ change in mole
☐ itching
☐ rash

Ear, Nose, Throat
☐ congestion
☐ ear discharge
☐ ear pain
☐ ear ringing
☐ headaches
☐ hearing loss
☐ nosebleeds
☐ sore throat

Home
☐ not enough food

Eyes
☐ blurred vision
☐ double vision
☐ eye discharge
☐ eye pain
☐ eye redness
☐ light sensitivity
☐ last eye exam (where/when): ____________

Cardiac
☐ chest pain
☐ leg pain when walking
☐ leg / ankle swelling
☐ palpitations
☐ short of breath when lying down
☐ waking up short of breath

Respiratory
☐ bloody sputum
☐ cough
☐ short of breath
☐ sputum production
☐ wheezing

Gastrointestinal
☐ abdominal pain
☐ black stool
☐ blood in stool
☐ constipation
☐ diarrhea
☐ heartburn
☐ nausea
☐ vomiting

Genitourinary
☐ blood in urine
☐ flank pain
☐ frequent urination
☐ leaking urine
☐ nighttime urination
☐ painful urination
☐ urgent urination

Musculoskeletal
☐ back pain
☐ falls
☐ joint pain
☐ muscle aches
☐ neck pain

Hematology
☐ allergies
☐ easy bruising or bleeding
☐ unusual thirst

Neurological
☐ dizziness
☐ loss of consciousness
☐ numbness
☐ seizures
☐ speech change
☐ tingling
☐ tremor
☐ weakness

Psychiatric
☐ anxiety
☐ daytime sleepiness
☐ don’t feel safe
☐ hallucinations
☐ memory loss
☐ suicidal ideas
☐ trouble sleeping

Please check any **family history of cancer:**

☐ Bladder
☐ Brain
☐ Breast
☐ Cervical
☐ Colon or Rectal
☐ Kidney
☐ Lung
☐ Melanoma
☐ Non-Hodgkin Lymphoma
☐ Ovarian
☐ Pancreatic
☐ Prostate
☐ Small Bowel
☐ Stomach
☐ Thyroid
☐ Uterine or Endometrial
☐ Other: __________
☐ Other: __________

Has anyone in your family had genetic testing? ☐ Yes ☐ No

Family History

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Name: ____
Date of birth: ____

Please let us know about your **family's health history:**

Name	Age or Deceased	Health Problems
Father:		
Mother:		
Brother: 1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________	____________ ____________ ____________ ____________ ____________	____ ____ ____ ____ ____
Sister: 1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________	____________ ____________ ____________ ____________ ____________	____ ____ ____ ____ ____
Grandfathers: Father side: ___________ Mother side: ___________	____________ ____________	____ ____
Grandmothers: Father side: ___________ Mother side: ___________	____________ ____________	____ ____
Aunts: Father side: ___________ ___________ Mother side: ___________ ___________	____________ ____________ ____________ ____________	____ ____ ____ ____
Uncles: Father side: ___________ ___________ Mother side: ___________ ___________	____________ ____________ ____________ ____________	____ ____ ____ ____
Children: 1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________	____________ ____________ ____________ ____________ ____________	____ ____ ____ ____

Thank you for completing this form.