MRN
Patient's name
Date of Birth

Welcome to the OHSU JBT Health and Wellness clinic. Please fill out this form so that your provider can review your medical history in detail. **If you have any specific condition(s) or problem(s) for which you are seeking care, please list them here:**

PAST MEDICAL HISTORY:

Please list any past medical history below with date of onset or diagnosis. Examples include asthma, diabetes, depression, anxiety, drug or alcohol dependency, high blood pressure, thyroid disease, autoimmune disease, chronic pain, gynecologic disorder.

Have you ever been hospitalized? Yes No If yes, please list the date(s) and reason(s)

Have you ever had surgery? Yes No If yes, please list the date(s) and type(s) of surgery:

ALLERGIES: Please list your medication allergies as well as other allergies (food, environmental) and the reaction that occurs.

MEDICATIONS/HERBS/VITAMINS/SUPPLEMENTS: Please list any medication you take on a regular basis (Include all birth control devices):

Name of Medication	Dose or Strength	How often do you take it?

FAMILY HISTORY: Has a member of your family had any of the following medical conditions? Please only include biological parents, grandparents, siblings, and children.
If you were adopted or you do not know your family medical history, please check here: ____

Problem:	Circle Yes or No		Relationship/Age of Onset
Alcohol/Drug Abuse	Yes	No	
Arthritis/Joint problems	Yes	No	
Asthma or Lung disease	Yes	No	
Blood disorder (e.g. anemia)	Yes	No	
Cancer (specify type)	Yes	No	
Dementia (e.g. Alzheimer's)	Yes	No	
Depression/Mental illness	Yes	No	
Diabetes	Yes	No	
Gastrointestinal problems	Yes	No	
Genitourinary problems	Yes	No	
Heart disease (e.g. heart attack, artery disease or arrhythmia)	Yes	No	
High blood pressure	Yes	No	
High cholesterol	Yes	No	
Liver disease	Yes	No	
Neurological Disorder	Yes	No	
Osteoporosis	Yes	No	
Seizure Disorder	Yes	No	
Stroke	Yes	No	
Thyroid Disease	Yes	No	
Other:	Yes	No	

SOCIAL HISTORY: Please tell us about your lifestyle and personal habits.
What is your gender identity? □ Male □ Female □ Transgender FTM □ Transgender MTF □ Genderqueer □ _____
What sex were you assigned at birth? □ Male □ Female

Are you a student or Postdoctoral Scholar?
If you are a student, what program are you in/what year?

Does your weight affect the way you feel about yourself?
Do you currently suffer with or have you ever suffered in the past with an eating disorder?
□ Yes □ No □in the past

Do you exercise regularly? □ Yes □ No If yes, describe: _____
Do you have any special dietary restrictions? □ Yes □ No If yes, describe_____

Do you use nicotine products? □ Yes □ No
If yes, what type? _____

Do you use drugs? □ Yes □ No
If yes, specify substance: _____

HEALTH MAINTENANCE: If you have had any of the following tests, please let us know the date (month and year)
Cholesterol: _____ □ Normal □ Abnormal
Diabetes screening test: _____ □ Normal □ Abnormal
HIV screening test: _____ □ Normal □ Abnormal
Gonorrhea/Chlamydia screening test: _____ □ Normal □ Abnormal

If you have had the following vaccines, please let us know the date (month and year)
Flu vaccine: _____
Pneumonia vaccine: _____
HPV vaccine (series of 3 shots): _____

SEXUAL HISTORY:
Are you currently sexually active? □ Yes □ No
If no, have you been sexually active in the past? □ Yes □ No
What is the gender of your sexual partner? _____
Do you and your sexual partner(s) practice safe sex? □ Yes □ No □ Not sure
Have you had a new sexual partner in the last year? □ Yes □ No
How many sexual partners have you had in your lifetime? _____

Do you have or have you ever had:
□ HIV □ Hepatitis B □ Hepatitis C □ Chlamydia □ Gonorrhea □ Herpes □ Syphilis □ Trichomonas □ Pelvic Inflammatory Disease (PID) □ Genital Warts □ Yeast infection □ Bacterial Vaginosis

Would you like STD screening today? □ Yes □ No

Do you feel safe in your relationship? □ Yes □ No □ NA
Within the past year: Have you been hit, slapped, kicked or otherwise physically hurt by someone? □ Yes □ No
Has anyone forced you to have sexual activities that made you feel uncomfortable? □Yes □ No

Gynecologic History:

CONTRACEPTIVE HISTORY:
Do you plan on becoming pregnant in the next year? □ Yes □ No
Do you need contraception? □ Yes □ No
Methods you've tried:
□ Condom □ Pill □ Patch □ Rhythm □ Ring □ Implant □ IUD □ Tubal ligation □ Plan B □ Other-
List any problems you have had with any of these:

What method are you using now if any? If pill, what brand? If IUD, which one?

Gynecological History:
Last pelvic exam: (Month/Year)
Last Pap smear: (Month/Year)
Result: □ Normal □ Abnormal
Where? _____
Have you ever had an abnormal Pap? □ Yes □ No
If yes, when? _____
If yes, did you require treatment?_____
Number of pregnancies____ births____
Do you examine your breasts? □ Yes □ No
Have you ever had a breast lump? □ Yes □ No
Have you had a Mammogram? □ Yes □ No
If yes, when was your last mammogram?_____
Mammogram results □ Normal □ Abnormal

Menstrual History: Age at onset: _____
Length of menses: _____
Time between menses: _____
Date of last menses: _____

Annual Questionnaire

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Mood:

	(Please Circle)	
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	No	Yes
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	No	Yes

***If you responded *"Yes"* to either of the previous questions, please complete the next set of questions on this page.**

***If you responded *"No"* to both the previous questions, proceed to the next page to complete the Alcohol screening.**

	(Please Circle)			
	(0)	**(1)**	**(2)**	**(3)**
1. Little interest or pleasure in doing things?	Not at all	Several Days	More than half the days	Nearly every day
2. Feeling down, depressed, or hopeless?	Not at all	Several Days	More than half the days	Nearly every day
3. Trouble falling or staying asleep, or sleeping too much?	Not at all	Several Days	More than half the days	Nearly every day
4. Feeling tired or having little energy?	Not at all	Several Days	More than half the days	Nearly every day
5. Poor appetite or overeating?	Not at all	Several Days	More than half the days	Nearly every day
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	Not at all	Several Days	More than half the days	Nearly every day
7. Trouble concentrating on things, such as reading the newspaper or watching television?	Not at all	Several Days	More than half the days	Nearly every day
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	Not at all	Several Days	More than half the days	Nearly every day
9. Thoughts that you would be better off dead, or of hurting yourself?	Not at all	Several Days	More than half the days	Nearly every day
1. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Alcohol Screening Questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals: 

12 oz. of beer  5 oz. of wine  1.5 oz. liquor (one shot)

	(Please Circle)	
MEN: How many times in the past year have you had 5 or more drinks in a day?	None	1 or more
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	None	1 or more

***If you responded *"1 or more"* to the previous question, please complete the next 10 questions on this page.**

***If you responded *"None"* to the previous question, proceed to the next page to complete the drug screening.**

(Please Circle)

	(0)	(1)	(2)	(3)	(4)
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	(Please Circle)	
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	None	1 or more

***If you responded *"1 or more"* to the previous question, please complete the next set of questions on this page.**

***If you responded *"None"* to the previous question, you have completed the form. Please hand to the Medical Assistant when you are roomed for your appointment.**

	(Please Circle)	
	(0)	**(1)**
1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M/W:	0	1-2	3-5	6+