THE Portland Clinic
We specialize in you.

PATIENT LABEL

REVIEW OF SYSTEMS & PAST MEDICAL HISTORY

Referring Physician _____

Primary Care Provider _____

Age _____ Height _____ ft _____ in

Weight _____ lbs

Please complete the front AND BACK of this form so that the physician you are seeing will have some background information about your medical condition.

Chief complaint: (the reason you have come in today)

_____

_____

Review of organ systems: If you have no symptoms in a certain area, please circle "N", if you do have symptoms please circle "Y" and explain in the space provided.

Y	N	General symptoms (fever, weight loss, etc) _____
Y	N	Eyes: _____
Y	N	Ears, nose, mouth, throat:_____
Y	N	Heart: _____
Y	N	Lungs: _____
Y	N	Stomach & intestines (reflux, heartburn, blood in stool: _____
Y	N	Bladder & urinary system: _____
Y	N	Muscles & bones: _____
Y	N	Skin and/or breasts: _____
Y	N	Neurological (brain & nervous system) _____
Y	N	Psychiatric (nerves or anxiety, depression) _____
Y	N	Endocrine (thyroid, hormones, cholesterol) _____
Y	N	Hematologic (bleeding disorders) _____
Y	N	Allergic/Immunologic: _____

(CONTINUED ON REVERSE ––►)

Medications

1) Drug allergies and reaction: _____

2) Preferred Local Pharmacy: _____

3) Drugs/medications/vitamins that you are currently taking including **dose and frequency:**

_____

_____

Past Medical History

Major illnesses: ❑ Allergies ❑ Arthritis ❑ Asthma ❑ Bleeding disorders ❑ Cancer

❑ Diabetes ❑ Ear infections ❑ Headaches ❑ Heart disease ❑ Hearing loss ❑ High blood pressure

❑ Thyroid disease ❑ Sleep apnea ❑ Other please list _____

_____

_____

Past Surgeries: ❑ Adenoidectomy ❑ Ear tubes ❑ Sinus ❑ Tonsillectomy ❑ Wisdom teeth

❑ Other, please list _____

Family History: Please circle any of the following severe illnesses that may run in your family and list the family member involved. (M=mother, F=father, B=brother, S=sister, MGM=maternal grandmother, MGF=maternal grandfather, PGM=paternal grandmother, PGF=paternal grandfather)

Anesthesia complications	M	F	B	S	MGM	MGF	PGM	PGF
Bleeding disorder	M	F	B	S	MGM	MGF	PGM	PGF
Cancer	M	F	B	S	MGM	MGF	PGM	PGF
Diabetes	M	F	B	S	MGM	MGF	PGM	PGF
Heart disease	M	F	B	S	MGM	MGF	PGM	PGF
High blood pressure	M	F	B	S	MGM	MGF	PGM	PGF
Migraines	M	F	B	S	MGM	MGF	PGM	PGF
Thyroid disease	M	F	B	S	MGM	MGF	PGM	PGF
Other:_____	M	F	B	S	MGM	MGF	PGM	PGF

Social History:

Occupation:_____

Tobacco use: ❑ Never

Current: Packs per day _____ Years _____

Former: ❑ Yes ❑ No Years _____

Second hand exposure: ❑ Yes ❑ No

Alcohol use: type_____amount per week_____