MCMC MID-COLUMBIA MEDICAL CENTER | COLUMBIA RIVER WOMEN'S CENTER
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A DESIGNATED PLANETREE PATIENT-CENTERED HOSPITAL

NEW PATIENT HEALTH HISTORY

Please be as complete as possible with your answers. If you are uncomfortable answering any questions, leave them blank and talk with your provider or nurse about them in person. We look forward to caring for you!

Name: _____

Name you like to be called: _____ Date of Birth: _____

GENERAL INFORMATION

Reason you are here: _____ ***LMP (Last Menstrual Period):*** _____

Do you have an advanced directive? ☐ Yes ☐ No If yes: ☐ DPA ☐ Living Will ☐ POLST ☐ HC Proxy ☐ DNR

In the past week, have you have any concerning symptoms such as: (Please circle all that apply)

- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Sore throat
- ☐ Blurred Vision
- ☐ Chest pain
- ☐ Palpitations
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Heartburn
- ☐ Nausea / Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea / Constipation
- ☐ Blood in Stool
- ☐ Pain with Urination
- ☐ Urgency
- ☐ Frequency
- ☐ Hematuria
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Headaches
- ☐ Depression / Anxiety
- ☐ Leaking of Urine
- ☐ Vaginal Discharge
- ☐ Breast lump
- ☐ Vaginal/vulvar itching
- ☐ Nipple Discharge
- ☐ Concerning Skin Changes

ALLERGIES

Have you ever had an *allergic reaction* (bad effect) to a medicine or a shot?

Allergic to	What happens

MEDICATIONS

Preferred Pharmacy: _____

Please list any medications or supplements (*no need to fill out if you brought a list or your medication bottles*)

Medication/Supplement	Strength or Amount	Last time it was taken

Patient Label

ZMC025 ZMC025

MEDICAL HISTORY

Do you currently have any of the following? (☒ *check all that apply*)

☐ High blood pressure	☐ Heartburn/ulcer	☐ Thyroid disorder
☐ Osteoporosis	☐ Asthma/emphysema	☐ Depression
☐ High cholesterol	☐ Bowel problems	☐ Anxiety
☐ Headaches/migraines	☐ Diabetes	☐ Cancer Type: _____

Other health problems?

_____

_____

_____

SURGICAL HISTORY

Please list all surgeries you have had and **dates** (if you can)

SURGERY	DATE(S)

FAMILY HISTORY

Family Member	Health problems	Age at Death	Cause
Mother			
Father			
Sister(s)			
Brother(s)			
Daughter(s)			
Son(s)			

Do you have any **other blood relatives** (aunts, uncles, grandparents, etc.) who have had the following health issues?

Diabetes _____

Heart Disease _____

Unexpected sudden death _____

Developmental Delay _____

Mental Health (Schizophrenia, Bipolar, etc.) _____

Cancer

Ovarian _____

Breast _____

Colon _____

Uterine _____

Other _____

WOMEN'S HEALTH HISTORY

Menopausal (answer the following questions) What age did your periods stop? _____

Hysterectomy? ☐No ☐Yes If yes, were your ovaries removed? ☐No ☐Yes Cervix removed? ☐No ☐Yes

Any vaginal bleeding in the last year? ☐No ☐Yes Symptoms of menopause? _____

Any hormone replacement therapy? ☐No ☐Yes If yes, what kind and for how long? _____

Pre/Perimenopausal (answer the following questions)

How long does your period last? _____ How many days between periods? _____ Flow: ☐Heavy ☐Moderate ☐Light

Recent changes or problems with periods: _____

Do you want to become pregnant in the next year? ☐No ☐Yes

Current method of birth control (*including vasectomy and tubal):* _____

Are you happy with this method? ☐Yes ☐No Describe issues _____

Past method(s) of birth control: _____ Problems? _____

Sexual History ☐ *I am not sexually active*

Sexually active with: ☐ Men ☐ Women ☐ Both

Are you currently sexually active (*within the past month*): ☐No ☐Yes Pain with intercourse? ☐No ☐Yes

Number of partners in the past year? _____ Concerns: _____

History of sexually transmitted infection (STI) or gynecologic infection? (chlamydia, gonorrhea, herpes, etc.) ☐No ☐Yes

If yes, what: _____

Date of last Pap test _____

History of abnormal Pap smears? ☐No ☐Yes, Result? _____

Treatment for abnormal Pap smears? ☐No ☐Yes If yes, what? (*LEEP, cryo, etc.*) _____

Pregnancy History ☐ *I have never been pregnant*

Have you had trouble becoming pregnant? ☐No ☐Yes _____

Please list approximate dates below:

Miscarriages _____ D&C done? ☐No ☐Yes Abortions_____ Ectopic_____

	Date of birth	Baby's weight	Sex	Weeks	Delivery (vaginal, with vacuum, forceps, c-section)	Complications (high blood pressure, diabetes, pre-eclampsia, etc.)
1						
2						
3						
4						
5						

SOCIAL HISTORY AND HABITS

Substance Use

Do you use tobacco? ☐ Never ☐ Yes ☐ Quit, Year:_____ ☐Smokeless ☐ Passive (secondhand smoke)

If yes, packs per day? _____ For how many years? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks per week _____

Do you now or have you ever used any drugs? ☐ No ☐ Yes If yes, how often _____

What type (*marijuana, methamphetamine, heroine, etc.)* _____ Last use: _____

Diet and Exercise

Do you drink soda? ☐ No ☐ Yes, Amount per day: _____

Servings of fruits and vegetables per day? _____ How often do you eat fast food? _____

How often do you exercise? ☐ Never ☐Occasional ☐2-3x/week ☐3-4x/week ☐Daily

Type? _____

Employment/Education

Occupation: _____ Hours per week? _____

Education: (*check highest level completed*) ☐Grade school ☐High school/GED ☐Tech school ☐College ☐ Graduate School

Homelife and Safety

Spouse or partner's name and occupation: _____

Who lives in your household? _____

ANNUAL SCREENING QUESTIONS

We ask all our patients about substance use, mood and relationships because ALL of these things can affect your health. Your answers to these questions will remain confidential, as does all your history. Please feel free to skip these questions if you prefer a verbal conversation with your provider.

Substance Use

How many times in the past year have you had 4 or more drinks in a day? ☐None ☐1 or more

How many times in the past year have you used a recreational drug or used a prescription medication for a nonmedical reason? ☐None ☐1 or more

Mood

During the last 2 weeks, have you been bothered by little interest or pleasure in doing things? ☐No ☐Yes

During the last 2 weeks, have you been bothered by feeling down, depressed, or hopeless? ☐No ☐Yes

Relationship Safety

Does a partner, or anyone at home hit, hurt or threaten you, or make you feel afraid? ☐No ☐Yes

Do you feel safe where you live? ☐No ☐Yes

Anything else you would like to talk about today?