The Corvallis Clinic™
Internal Medicine

INTRODUCTORY PATIENT INFORMATION

Legal Name ______________________ Date ____________

Preferred Name ______________________ Phone ____________

DOB ____________ Age ____________

Referral Source ____________ Primary Care Physician ____________

School ____________ Grade ____________

Person Filling out Form ____________ Relationship to Patient ____________

ADDITIONAL MEDICAL PROVIDERS

Name	Specialty	Location

PRESENTING PROBLEM – WHY ARE YOU HERE TODAY?

In your own words what happened or prompted you to make this appointment? Use the back page if needed.

When did it start? How long has it been going on?

What does it feel like? What makes it better or worse?

Did something trigger a change in health?

When was the last time the patient felt well?

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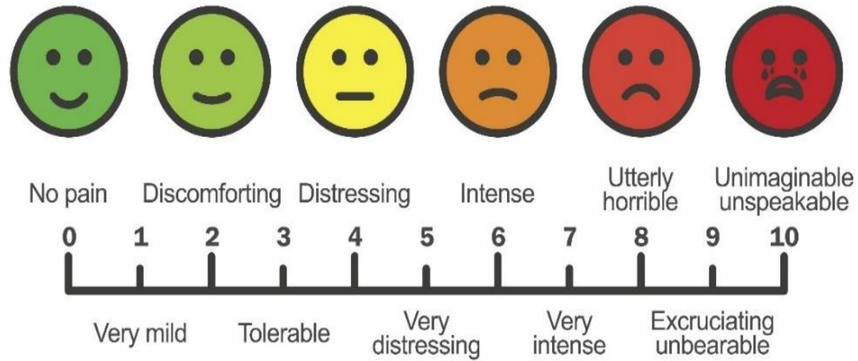
CURRENT PAIN SCALE 1-10



MOTOR VEHICLE CLAIMS

Is this visit related to a Motor Vehicle Accident: Yes ☐ No ☐

ALLERGIES

Name	**Rection**

NUTRITIONAL SUPPLEMENTS *(VITMAINS, MINERALS, HERBS)*

Name	Dose	Frequency	Start Date	Reason for Use

Please check here and use the back of this form to continue supplement list if needed. ☐

CURRENT MEDICATIONS

Name	Dose	Frequency	Start Date	Reason for Use

Please check here and use the back of this form to continue medication list if needed. ☐

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PRIOR MEDICATION AND REASON FOR STOPPING

Name	Dose	Frequency	Start Date	End Date	Reason for Use and Stopping

Please check here and use the back of this form to medication list if needed

COMPREHENSIVE HEALTH BACKGROUND

CURRENT MEDICAL PROBLEMS IN ORDER OF PRIORITY

Name	**Severity (Mild/Moderate/Severe)**	**Prior treatments**

DENTAL PROCEDURES

Procedure	**Date(s)**	**Duration or number as applicable**
Wisdom teeth removal		
Other extractions		
Braces		
Permanent retainer		
Removable retainer		
Night guard		
Implants		
Root canal or cavities		

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FAMILY HISTORY

	Mother	Father	Sister(s)	Brother(s)	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Aunt(s)	Uncle(s)
Age if living										
Age at Death										
Adopted unknown										
Allergies										
Asthma										
Blood disease										
CAD-Heart attack										
Cancer-what kind										
Crohn's disease										
Dementia										
Depression										
Diabetes Type 1										
Diabetes Type 2										
Heart failure										
High cholesterol										
High blood pressure										
Irritable bowel disease										
Kidney disease										
Obesity										
Osteoarthritis										
Osteoporosis										
Stroke										
Substance abuse										
Thyroid disease										
Ulcerative colitis										
Other										

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SURGERIES AND PROCEDURES

What kind, side if applicable	Date	Why was it done

HOSPITALIZATIONS

For what	Date(s)	Where

TRAUMA – ANY MAJOR INCIDENT

How? (MVA, falls)	Date(s) or approximate age	What was injured (bone fractures, organs)

GENERAL HEALTH SCREENING

	Date and if result abnormal
Dental Exam	
Eye Exam	
Last Full Physical	

PERINATAL HISTORY: CHOOSE THOSE THAT APPLY

PREGNANCY COMPLICATIONS IN MOM

Toxemia _______ Illness ____________________________________

Threat of Miscarriage _______ Infection ____________________________________

Hospitalizations _______ Operation ____________________________________

Full-Term ☐ // Premature: # of weeks ☐_______ // Birth Weight/Length ______________________

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TYPE OF LABOR
Spontaneous ☐ // Induced ☐ // Duration (hours) ________

TYPE OF DELIVERY
Normal ☐ // Breech ☐ // Caesarean ☐ // Forceps ☐ // Vacuum ☐ // Apgar Scores __________

COMPLICATIONS
Cord around neck ☐ // Hemorrhage ☐ // Infant injured during delivery ☐ // Other___________________

POST DELIVERY PERIOD
Jaundice ☐ // Cyanosis (turned blue) ☐ // Incubator ☐ // Infection ☐

Number of days infant was in hospital after delivery, due to infant's condition: _______
Breast fed for how long? ________________ Bottle fed for how long? _________________

INFANCY: WERE ANY OF THE FOLLOWING PRESENT? CHOSE ALL THAT APPLY
Colic / Fussy ☐ Reflux / Vomiting ☐ Difficulty Feeding ☐

COORDINATION & MILESTONES

As a toddler and into childhood	**More than average Good**	**Average**	**Less than average Poor**
Walking			
Running			
Athletic Abilities			
Hand Writing			
Clumsiness			
Milestones	Early	Normal	Late
Rolled over			
Sat up			
Crawled			
Walked			
Toilet Trained			

INTERESTS

Hobbies and Interests? Comments? Is there anything we need to know that we haven't already asked?

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REVIEW OF SYMPTOMS

General: No problems ☐ Abnormal Labs/Tests, Unexplained Weight/Height Changes, Any Domestic Abuse/Violence/Concern, Fevers, Chills, Lack Of Energy, Loss Of Appetite, Night Sweats

Eyes: No problems ☐ Blurred Vision, Double Vision, Cataracts, Glaucoma, Dry eyes, irritation

Ears: No problems ☐ Ringing In Your Ears, Room Spins, Hearing Loss, Recurrent Infections

Nose: No problems ☐ Sinus Problems, Postnasal Drip, Congestion, Nose Bleeds

Throat: No problems ☐ Hoarseness, Change In Voice, Difficulty Swallowing, sore throat

Heart: No problems ☐ Chest Pain, Palpitations, Skipped Beats, Swelling Of Feet Or Legs

Lungs: No problems ☐ Cough, Shortness Of Breath, Apnea, Wheezing, Oxygen At Home, Coughing Up Blood

Stomach/Bowels: No problems ☐ Abdominal Pain, Poor Appetite, Nausea, Vomiting, Diarrhea, Constipation, IBS, Heartburn/Reflux, Food Intolerances, Stool Abnormalities, Change In Bowel Habits, Hemorrhoids, Blood In Stool

Female: No problems ☐ Pain With Period, Heavy/Light Menstrual Flow, Irregular Periods, Pain With Intercourse, Discharge, Itching, PMS, Hot Flushes, Fibrocystic Breast Disorder, Breast Masses, Nipple Discharge, Tenderness

Male: No problems ☐ Difficulty Starting The Stream, Impotence, Discharge

Urinary: No problems ☐ Urgency, Frequency, Burning, Incontinence, Get Up At Night To Urinate

Musculoskeletal: No problems ☐ Muscle/Joint Pain, Scoliosis, Short Leg, Wear A Lift/Orthotic, Wear A Brace

Skin: No problems ☐ Rashes, Lesions/Moles, Sores That Don't Heal, Abnormal Nails, Abnormal Hair

Neurologic: No problems ☐ Headaches, Numbness/Tingling, Dizziness, Seizures, Memory Loss, Weakness

Psychiatric: No problems ☐ Anxiety, Depression, Suicidal, Mood Swings, Insomnia/Sleep Disturbance,

Endocrine: No problems ☐ Fatigue, Hair Loss, Dry Skin, Cold Intolerance, Drink A Lot, Eat A Lot, Urinate A Lot

Blood/Lymph: No problems ☐ Swollen Glands That Don't Go Away, Anemia, Bruise Easily, Easy Bleeding

Allergic/Immunity: No problems ☐ Frequent Colds/Infections, Hay Fever, Sores That Don't Heal

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ALL OF THE ABOVE ITEMS WERE REVIEWED WITH THE PATIENT BY THE PHYSICIAN AND ARE CONFIRMED AS NOTED ABOVE AND DOCUMENTED IN THE MEDICAL RECORD.

Dr. Rosendahl ____ **Date** _________________

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