STONE MEDICAL, PC

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ASHLAND, OR 97520

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Patient's Name: ____ **DOB:** _____________________ **Today's Date:** _________________________

For what reason are you here today? ____
____

PLEASE CHECK ALL CONDITIONS THAT APPLY

GENERAL
- ☐ Serious Infections (E.g. pneumonia)____________
- ☐ Diabetes Mellitus/Insulin Resistance
- ☐ Rheumatic Fever
- ☐ HIV Infection
- ☐ Cancer (where?)____________

CVS
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Angina
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Abnormal Heart Rhythm
- ☐ Blood Clots in Veins
- ☐ Blocked Arteries in Neck
- ☐ Blocked Arteries in Legs

HEENT
- ☐ Glaucoma
- ☐ Allergies "hay fever"
- ☐ Frequent Ear Infections
- ☐ Frequent Sinus Infection

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ Blood Clots in Lungs
- ☐ Sleep Apnea

MUSCULOSKELETAL/ EXTREMITIES
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Neck Pain (herniated disc)
- ☐ Back Pain (herniated disc)

LYMPHATIC/HEMATOLOGIC
- ☐ Thyroid
- ☐ Over active Thyroid
- ☐ Under Active Thyroid
- ☐ Transfusion
- ☐ Anemia

GI/GU
- ☐ Stomach Ulcers
- ☐ Ulcerative Colitis
- ☐ Crohns Disease
- ☐ Bleeding from Intestines
- ☐ Diverticulitis
- ☐ Colon Polyps
- ☐ Irritable Bowel Disease
- ☐ Hepatitis
- ☐ Cirrhosis of the Liver
- ☐ Liver Failure
- ☐ Pancreatitis
- ☐ Gallstones
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Disease
- ☐ Endometriosis
- ☐ Sex Transmitted Infection

SKIN/BREAST
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Fibrocystic Breast Disease

NEUROLOGIC/PSYCHIATRIC
- ☐ Chronic Vertigo (Meniere's)
- ☐ Peripheral Nerve Disease
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Anxiety

Doctors's Notes:____
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PLEASE CHECK ALL SURGERIES THAT APPLY AND THE DATE THEY WERE PREFORMED

YEAR:	YEAR:	YEAR:	YEAR:
-----Angioplasty	-----Trauma Related Surgery	-----Stomach Surgery	-----Tubal Ligation
-----Carotid Artery Surgery	-----Back or Neck Surgery	-----Inguinal Hernia	-----C-Section
-----Other Vascular Surgery	-----Hip Surgery	-----Colonoscopy	-----Hysterectomy
-----Coronary Bypass Surgery	-----Knee Surgery	-----Gallbladder	-----Ovary Removal
-----Chest/Lung Surgery	-----Carpal Tunnel Surgery	-----Appendectomy	-----Breast Surgery
-----Tonsillectomy	-----Sinus Surgery	-----Prostate Surgery	-----Thyroid Surgery
-----Neurosurgery	-----Ear Surgery	-----Bladder Surgery	-----Other_______________

Doctors's Notes:____
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PLEASE INDICATE WHEN YOU HAD THE FOLLOWING PREVENTATIVE TESTS AND SERVICES

-----Cardiac Angiogram	-----Flu Vaccine	-----Prostate Cancer Blood Test	-----Mammogram/Breast Exam
-----Stress Test	-----Pneumonia Vaccine	-----Rectal Exam	-----Pap Smear
-----Echocardiogram	-----Tetanus Vaccine	-----Colon Cancer Stool Test	-----Date of last Physical Exam
-----Chest E-ray	-----Hepatitis Vaccine	-----Flexible Sigmoidoscopy	-----Other________________
-----EKG	-----Bone Density	-----Barium Enema	

Doctors's Notes:____
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Please list any allergies or intolerance to drugs or other substances. ____
____
____
____

Please list the medications currently taken, their dosages, and how many times per day you take them.

____ ____

____ ____

____ ____

____ ____

FAMILY MEDICAL HISTORY

Please check or list any major illness in your family members: (Mother, Father, Brothers, Sisters, or Children)

☐ Tuberculosis	☐ Diabetes Mellitus	☐ Kidney Disease	☐ Breast Cancer
☐ Emphysema	☐ Thyroid Disease	☐ Epilepsy	☐ Ovarian Cancer
☐ Heart Disease	☐ Anemia	☐ Neurological Disease	☐ Colon Cancer
☐ High Blood Pressure	☐ Hemophilia	☐ Liver Disease	☐ Prostate Cancer
☐ Osteoporosis	☐ ___________________	☐ _________________	☐ __________________

Notes: ____
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PERSONAL INFORMATION

Please write in or circle the information that applies to you

Occupation:

Education	**Sexuality**	**Marital Status**	**Living Status**	**Diet**	**Exercise**	**Alternative Medicine**
primary	heterosexual	single	alone	none	none	holistic
secondary	homosexual	married	with spouse	low fat	walking	chiropractic
college	bisexual	divorced	with parents	low choesterol	aerobics	homeopathy
post grad	transsexual	widowed	assisted living	low carb	weightlifting	acupuncture
doctorate		separated	nursing home	vegetarian	___days/wk	herb

Tobacco	**Alcohol**	**Illicit Drugs**	**Caffeine**
Never / past / active	Never / past / active	Never / past / active	Never / past / active
Cigarette / cigar / pipe	Liquor / wine / beer ____drink per	Cocaine / marijuana	Coffee / tea / soda
Snuff / dip / chewing	Day / week / month	Heroin / amphetamine	____can / cup per day
Start_______ Stop ________		Barbiturate / LSD / PCP	
Pack per day __________	AA / Alcohol Rehab	IV Drug Abuse / Drug Rehab	

Doctors's Notes:____
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