

Patient Information
Sellwood Family Medicine LLC
1567 SE Tacoma Street, Portland, OR, 97202 ☎ 503.233.8113

Today's date: ____ / ____ / ____

PERSONAL INFORMATION	
Name: _____	_____
<small>Last</small>	<small>First M.I.</small>
Home Address: _____	
<small>Street Address</small>	<small>Apt # City State Zip Code</small>
Home Phone: _____	Cell Phone: _____
Date of birth: ____ / ____ / ____	Age: ____ Sex: m / f

EMPLOYER INFORMATION
Employer's Name: _____
Employer's Address: _____

Employment Status (circle): not employed / full time / part time / retired
Work phone: _____
Driver's License #: _____

Were you referred to this clinic? yes / no
If so, by whom? _____

If not, how did you hear about us?

In case of an emergency, whom should we
contact? Name: _____
Phone: _____
Relationship: _____

INSURANCE INFORMATION

Insurance Company Name: _____

Insurance Company Address: _____

Street Address City State Zip Code

Policy Holder Name: _____ Relationship to you: self/spouse/child/other

Policy Holder employer: _____ employer phone: _____

Policy Holder's date of birth: ____ / ____ / ____

Secondary Insurance Company Name: _____

Insurance Company Address: _____

Street Address City State Zip Code

Policy Holder Name: _____ Relationship to you: self/spouse/child/other

Policy Holder employer: _____ employer phone: _____

Policy Holder's date of birth: ____ / ____ / ____

Your marital status: _____ Your Student status: non student / full time / part time

FINANCIAL POLICY

We are committed to providing you with the best possible medical care at the lowest possible cost. Prompt payment allows us to control costs, which ultimately keeps our fees to a minimum. The following is a statement of our financial policy that we require you to read and sign prior to your first treatment:

Payment in full is due at the time of service. We accept both cash and checks. Our practice participates with some insurance carriers and as a courtesy to patients, we will file claims directly with the respective insurance company. At the time of service, we require payment for any non-covered services, standard co-pay, and coinsurance. Patients whose co-insurance is based upon a percentage of the charge should pay their designated percentage of the bill at the time of service. If you have a deductible that has not been met, your insurance carrier will apply services to that deductible.

Patients are responsible for obtaining the necessary referral form, if their insurance company requires one. In the event that you are seen (by your acknowledgement) without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us. We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

Please be aware that few insurance companies attempt to cover all medical costs. Some companies pay fixed allowance for each procedure/service while others pay only a percentage of the costs. Our practice is committed to providing the best treatment to you, and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates that may bear no relationship to the current standard and cost of care in this area.

Returned checks and balances referred to outside collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

Unless we are notified at least 24 hours in advance, our policy is to charge for missed appointments.

Our practice believes that a good doctor-patient relationship is based upon effective communications. If you have any questions, please feel welcome to contact us at 503-233-8113.

By signing below I agree that I have read and understand this policy.

SIGNATURE: _____

DATE: _____

Health History Questionnaire

Your Name: _____ Date: _____

What are the concerns for which you are seeking care? (Primary concern first)

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____
4. _____ Date of onset: _____

Are you seeking primary care from Dr. Chapman? Yes No

If No, who is your primary care physician? _____
(Name) (Phone if known)

For what concern did you last receive health or medical care? _____

Medications and Supplements

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking? _____

Circle each that you currently use:

Laxatives Pain relievers Antacids Cortisone Antibiotics Heart/Blood medication
Allergy Medication Thyroid medication Sleeping pills Anti-depressants Birth Control Pills
Hormones Appetite Suppressants

Do you have any known contagious diseases at this time? Yes No

If yes, what? _____

Family History

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate which relatives who the disease.

Cancer _____ Diabetes _____ Epilepsy _____
Heart Disease _____ High Blood Pressure _____ Stroke _____
Anemia _____ Kidney Disease _____ Glaucoma _____
Allergies _____ Asthma _____ Mental Illness _____

Have you have any of the following Childhood Illnesses (check if yes)

Scarlet fever ___ Diphtheria ___ Rheumatic fever ___ Mumps ___ Measles ___ German measles ___
Have you had any immunizations? Yes No Negative Reactions? _____

Hospitalizations, Surgery, X-Ray and Special Studies

What hospitalizations, surgeries, x-rays, or special studies have you had?

_____ year: _____ year: _____
_____ year: _____ year: _____
_____ year: _____ year: _____

Past medical history

Do you have a history of any of the following?

___ Head trauma ___ Motor vehicle accident

Allergies

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:

General

Weight _____ lbs. Weight 1 year ago _____ lbs. Maximum Weight _____ lbs. When? _____
Height _____ Blood Type _____

Lifestyle

Main interests and hobbies?

Exercise, what kind? _____

How often do you exercise? _____

Average hours of sleep _____

Do you have a supportive relationship? _____

Do you have a religious/spiritual practice? _____

How important is it to your life/ health?

Place a check mark by the items that pertain to you and your lifestyle.

___ Use recreational drugs

___ Drink coffee

___ Drink cola or other sodas

___ Take vacations

___ Spend time outside

___ Use alcoholic beverages # per week _____

___ Treated for alcoholism / addiction

___ Use tobacco currently

___ Used tobacco in the past

How many years? _____

How many packs per day? _____

Review of Systems

Please indicate if you are currently experiencing any of the following symptoms (Y)
or have had any of these symptoms in the Past (P).

SKIN

- Rashes
- Eczema/ Hives
- Acne/ Boils
- Chronic Itching
- Fungal Infections
- Color change
- Hair Loss
- Dry skin/ scalp
- Lumps
- Night Sweats
- Slow wound healing
- Ulceration
- Easy bruising
- Flushing

NOSE AND SINUS

- Frequent colds
- Nose bleeds
- Stuffiness
- Hay fever
- Sinus problems
- Loss of smell

EYES AND EARS

- Itchy eyes
- Dry eyes
- Swollen/ painful eyes
- Red Eyes
- Blurriness
- Floaters
- Cataracts
- Color Blindness
- Glaucoma
- Haring loss
- Ringing in ears
- Earaches/ infection

MOUTH AND THROAT

- Sore throat
- Teeth grinding
- pain in tongue/ lips
- Gum problems
- Hoarseness
- Difficulty swallowing

HEAD/ NECK

- Headache/ migraine
- Light headed
- Dizziness
- Jaw pain
- Goiter
- Swollen Glands
- Pain or Stiff neck
- TMJ

RESPIRATORY

- Congestion
- Wheezing
- Bronchitis
- Pneumonia
- Asthma
- Emphysema
- Painful Breathing
- Shortness of breath
- Tuberculosis
- Chronic Cough
- Coughing blood

CARDIOVASCULAR

- Heart disease
- Chest pain
- High blood pressure
- Low blood pressure
- Heart Murmur
- Irregular heart beat
- Palpitations

CIRCULATION

- Swelling
- Anemia
- Varicose veins
- Cold hands/ feet

ENDOCRINE

- Hypothyroid
- Hypoglycemia
- Excessive thirst
- Excessive hunger
- Fatigue
- Depression

IMMUNE

- Chronic Fatigue Synd.
- Frequent infections
- Swollen glands

MENTAL/ EMOTIONAL

- Mood Swings
- Anxiety/ nervousness
- Depression
- Poor focus
- Poor Memory

NEUROLOGIC

- Seizures
- Paralysis
- Numbness/ tingling
- Weakness
- Tics

DIGESTION

- Trouble swallowing
- Heartburn
- Acid reflux
- Ulcer
- Nausea/ vomiting
- Gas/ Bloating
- Excessive gas
- Diarrhea
- Constipation
- Abdominal pain
- Mucous in stool
- Blood in stool
- Hemorrhoids
- Itchy/ Burning anus
- Rectal Pain
- Gall bladder pain
- Jaundice (yellow skin)

URINARY

- Pain on urination
- Increased frequency
- Frequent infections
- Kidney stones
- Inability to hold urine
- Frequency at night
- Blood in urine
- Sexually transmitted infection

MALE ONLY

- Hernias
- Testicular masses
- Testicular pain
- Prostate
- Discharge or sores
- Sexual dysfunction

GENERAL

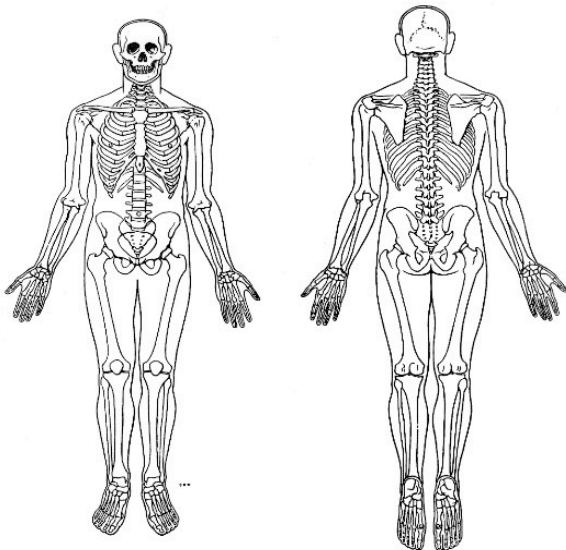
- Poor Sleep / Insomnia
 - disturbed Sleep
 - Fatigue / Low Energy
 - Chills
 - Fevers
 - Poor Appetite
 - Constant Hunger
 - Peculiar taste in mouth
 - Low Libido
 - Experience High Stress
- Are you sexually active?
Yes No

FEMALE ONLY

- Irregular cycles
- Bleeding between cycles
- Endometriosis
- Difficulty conceiving
- Painful menses
- Pain during intercourse
- Clotting

FEMALE CONTINUED

- Nipple discharge
 - Breast Lumps
 - Breast pain/tenderness
 - PMS
 - Abnormal PAP
- Date of last Pap smear _____
- Ovarian symptoms
 - Vaginal discharge
 - Heavy or excessive flow
- Age at first menses _____
Length of Cycle _____
Age of last menses (if menopausal) _____
Duration of Flow _____
Date of last period _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Date of last mammogram _____



On the diagram to the left, please circle any areas in which you are experiencing pain.
Please describe that pain below.
