Mill-e-Moto
12005 SW 70th Ave Tigard, OR 97223
p: (503)372-6463 f: (503)214-8470

Patient Health History

Welcome to Mill-e-Moto. It is our goal to help each patient improve their quality of life and to achieve optimum health. In order to serve you best we encourage you to fill out this survey in as much detail as possible. All symptoms that you experience are relevant and important to us and will be held in strict confidence.

Name: ____ Date: ______/______/______
(first) (middle) (last)

Address: ____________________________ City/State: ___________________ Zip:__________

Telephone#: (H)_____________ (C)_____________ E-Mail:____________________________

Select your choice: *Yes I do* / *No I do not* agree to receive occasional emails (Re: appointments, check-ins and clinic info).

Emergency Contact (Name /Telephone #):____

Date of Birth: _______/_______/_______ Age: _______ Gender: __________ Marital status: ___________

1. When and where did you last receive health care? ________________________________

For what reason? ____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns, in order of importance, that have brought you to Mill-e-Moto:

Condition **Past Treatment**

1) ________________________ ______________________________________
How does this condition affect you? ______________________________________

2) ________________________ ______________________________________
How does this condition affect you? ______________________________________

3) ________________________ ______________________________________
How does this condition affect you? ______________________________________

4) ________________________ ______________________________________
How does this condition affect you? ______________________________________

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking and their dosage:

____

____

6. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you?________________

7. Do you have any infectious diseases? Y N If yes, please identify: ______________________________

8. **Height:** __________ **Weight:** Currently: __________ Past Maximum: _____________ When? _______________

9. **Blood Pressure:** What is your most recent blood pressure reading? _______/_______ When was this reading taken? ________

10. **Childhood Illness:** (Please check any that you have had)

ڤScarlet Fever ڤDiphtheria ڤRheumatic Fever ڤMumps ڤMeasles ڤGerman Measles ڤChicken Pox

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11. **Immunizations** (please check any that you have had):

ف Polio ف Tetanus ف Measles/Mumps/Rubella ف Pertussis ف Diphtheria ف Hepatitis A & B ف Others: ___________

12. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

13. **X-Rays/CAT Scans/MRI’s/NMR’s/Special Studies:**

Reason	When	Reason	When

14. **Family History:**
***Check those applicable*:**

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health (G=Good, P=Poor)						
Cancer						
Diabetes						
Heart Disease						
Stroke						
Mental Illness						
Asthma/Hay fever/Hives						
Kidney Disease						
Age (at death)						
Cause of Death						

Please check the RED (left) box for any symptoms you have NOW, and check the BLUE (right) box for any that you have experienced in the PAST

15. **Emotional**
- Mood Swings
- Nervousness
- Mental Tension

16. **Energy and Immunity**
- Fatigue
- Slow Wound Healing
- Chronic Infections
- Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, & Throat**
- Impaired Vision
- Eye Pain/Strain
- Glaucoma
- Glasses/Contacts
- Tearing/Dryness
- Impaired Hearing
- Ear Ringing
- Earaches
- Headaches
- Sinus Problems
- Nose Bleeds
- Frequent Sore Throats
- ف Teeth Grinding
- TMJ/Jaw Problems
- Hay Fever

18. **Respiratory**
- Pneumonia
- Frequent Common Cold
- ف Difficulty Breathing
- Emphysema
- Persistent Cough
- Pleurisy
- Asthma
- Tuberculosis
- Shortness of Breath
- Other Respiratory Problems

19. **Cardiovascular**
- Heart Disease
- Chest Pain

Patient Initials: ________ Patient DOB:___/___/____

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Cardio Cont'd
- Swelling of Ankles
- High Blood Pressure
- Palpitations/Fluttering
- Stroke
- Heart Murmurs
- Rheumatic Fever
- Varicose Veins

20. **Gastrointestinal**
- Ulcers
- Changes in Appetite
- Nausea/Vomiting
- Epigastric Pain
- Excessive Gas
- Heartburn
- Gall Bladder Disease
- Liver Disease
- Hepatitis B or C
- Hemorrhoids
- Abdominal Pain

21. **Genito-Urinary Tract**
- Kidney Disease
- Painful Urination
- Frequent UTI
- Frequent Urination
- Kidney Stones
- Impaired Urination
- Blood in Urine
- Frequent Urination at Night

22. **Female Reproductive/Breasts**
- Irregular Cycles
- Breast Lumps/Tenderness
- Nipple Discharge
- Heavy Flow
- Vaginal Discharge
- Premenstrual Problems
- Clotting
- Bleeding Between Cycles
- Menopausal Symptoms
- Difficulty Conceiving
- Painful Periods

23. **Male Reproductive**
- Sexual Difficulties
- Prostrate Problems
- Testicular Pain/Swelling
- Penile Discharge

24. **Musculoskeletal**
- Neck/Shoulder Pain
- Muscle Spasms/Cramp
- Arm Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Leg Pain
- Joint Pain (if so, where?):

____
____

25. **Neurological**
- Vertigo/Dizziness
- Paralysis
- Numbness/Tingling
- Loss of Balance
- Seizures/Epilepsy

26. **Endocrine**
- Hypothyroid
- Hypoglycemia
- Hyperthyroid
- Diabetes Mellitus
- Night Sweats
- Feeling Hot or Cold

27. **Other**
- Anemia
- Cancer
- Rashes
- Eczema/Hives
- Cold Hands/Feet

28. **Menstrual/Birthing History:** a. Age of First Menses: _______ b. # of Days of Menses: _______ c. Length of Cycle: _______
d. Birth Control Type: ________ e. # of Pregnancies: ________ f. # of Miscarriages: ________ g. # of Abortions: ________
h. # of Live Births: ________
Is there anything else we should know? ____
____

29. **Lifestyle:**

a. Do you feel you have a healthy diet? Y N Do you typically eat three meals per day? Y N
b. Exercise routine: ____
c. On average, how many hours per night do you sleep? ________ Do you wake rested? Y N
d. Level of education completed: High School Bachelors Masters Doctorate Other
e. Occupation: ______________________ Employer: ____________________ Hours/Week: _______
Do you enjoy work? Y N Why/Why not? ____
f. Nicotine/Alcohol/Caffeine Use: ____
g. Have you experienced any major traumas? Y N Explain: ______________________________
____
h. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? __________
i. Interests and hobbies: ____

How did you hear about us? ____