Cascade Internal Medicine Specialists LLC

Health History Intake Form

Your physician today:

- ☐ **Jeffrey Absalon, MD**
- ☐ **Sanaz Askari, DO**
- ☐ **Mark Backus, MD**

Today's Date:_____

Patient Name:_____

Date of Birth:_____ **Age:**_____

Previous Primary Care Physician (if any):_____

Phone:_____ **Address:**_____

Other Physicians involved in your care:_____

_____

Reason for visit today:

_____

_____

_____

Allergies (Medication/Food, indicate reaction): ☐ None

_____

_____

_____

Medication List: (Please list name/dose/frequency if known)

_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History: (please indicate deceased or alive, medical issues and age)

Father:_____

Mother:_____

Siblings:_____

_____

Grandparents:_____

Habits:

Alcohol: ☐ None ☐ Yes: How many drinks/day _____frequency/week _____What kind_____
Tobacco: ☐ None ☐ Yes: Chew or smoke?_____ How many/day _____ since_____
Caffeine: ☐ None ☐ Yes: What kind_____ How many/day _____
Other Recreational Drugs: ☐ None ☐ Yes: What kind_____ How many/day _____
Do you drive? ☐ Yes ☐ No Do you always wear a seatbelt? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No If yes, how much?_____

Social History:

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled
Current Occupation _____Former Occupation _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Domestic Partner
Sexual preference: ☐ Men ☐ Women ☐ Both
Children (age):_____
Hobbies:_____
Sports:_____
Pets:_____
Other:_____

Past Surgical History (indicate date if known)

- ☐ None
- ☐ Cataracts_____
- ☐ LASIK_____
- ☐ Tonsillectomy_____
- ☐ Thyroidectomy_____
- ☐ Adenoidectomy_____
- ☐ Coronary Bypass_____
- ☐ Cardiac Stents_____
- ☐ Pacemaker_____
- ☐ Heart Valve_____
- ☐ Gall Bladder_____
- ☐ Appendectomy_____
- ☐ Bowel/Stomach Resection_____
- ☐ Hemorrhoidectomy_____
- ☐ Bariatric surgery_____
- ☐ Hysterectomy_____
- ☐ Endoscopy_____
- ☐ Colonoscopy_____
- ☐ Hernia_____
- ☐ Spinal Surgery_____
- ☐ Tubal Ligation_____
- ☐ Bladder surgery_____
- ☐ Prostate surgery/resection_____
- ☐ C-Section_____
- ☐ Orthopedic/joints_____
  _____
- ☐ Other_____
  _____

_____
_____
_____
_____

Past Medical History:

Head Aches	☐ Yes	☐ No	Date: _____
Stroke	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Pneumonia	☐ Yes	☐ No	_____
Diabetes (Type 1 or Type 2)	☐ Yes	☐ No	_____
Thyroid Disease (Low or High)	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____
Macular Degeneration	☐ Yes	☐ No	_____
Hearing Loss	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Blood Clots	☐ Yes	☐ No	_____
☐ Pulm Emboli (lung clots)	☐ Yes	☐ No	_____
☐ DVT (leg clots)	☐ Yes	☐ No	_____
Heart Burn, Reflux	☐ Yes	☐ No	_____
Stomach Ulcers	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
☐ Coronary Disease	☐ Yes	☐ No	_____
☐ MI/heart attacks	☐ Yes	☐ No	_____
☐ Congestive Heart Failure	☐ Yes	☐ No	_____
☐ Atrial Fibrillation	☐ Yes	☐ No	_____
☐ Angina	☐ Yes	☐ No	_____
☐ Valve Disorder	☐ Yes	☐ No	_____
High Cholesterol	☐ Yes	☐ No	_____
Gastrointestinal Bleeding	☐ Yes	☐ No	_____
Hepatitis (A, B, C)	☐ Yes	☐ No	_____
HIV / AIDS	☐ Yes	☐ No	_____
Chronic Wounds	☐ Yes	☐ No	_____
Cancer (type)	☐ Yes	☐ No	_____
Urinary Tract Infections	☐ Yes	☐ No	_____
Incontinence	☐ Yes	☐ No	_____
Kidney Stones	☐ Yes	☐ No	_____
COPD (Emphysema, Bronchitis)	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Bipolar Disorder	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Fibromyalgia	☐ Yes	☐ No	_____
Chronic Fatigue Syndrome	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Gout	☐ Yes	☐ No	_____
Osteoporosis	☐ Yes	☐ No	_____
Prostate Disease	☐ Yes	☐ No	_____
Breast Disease	☐ Yes	☐ No	_____
Erectile Dysfunction	☐ Yes	☐ No	_____

Other_____

Review of Systems (√ Yes or No for symptoms in past 6 months, circle for symptoms TODAY)

Constitutional/Endocrine
- ☐ Yes ☐ No **Fever**
- ☐ Yes ☐ No **Chills**
- ☐ Yes ☐ No **Weakness/Fatigue**
- ☐ Yes ☐ No **Weight Loss**
- ☐ Yes ☐ No **Weight Gain**
- ☐ Yes ☐ No **Insomnia**
- ☐ Yes ☐ No **Snoring**
- ☐ Yes ☐ No **Excessive thirst**
- ☐ Yes ☐ No **Excessive urination**
- ☐ Yes ☐ No **Cold or Heat intolerance**

Other:_____

HEENT
- ☐ Yes ☐ No **Sore Throat**
- ☐ Yes ☐ No **Stiff neck**
- ☐ Yes ☐ No **Change in your voice**
- ☐ Yes ☐ No **Sinus Drainage**
- ☐ Yes ☐ No **Sinus Head Ache**
- ☐ Yes ☐ No **Nose Bleeds**
- ☐ Yes ☐ No **Ear ache/drainage**
- ☐ Yes ☐ No **Hearing Loss**
- ☐ Yes ☐ No **Ringing in your ears**
- ☐ Yes ☐ No **Blurred Vision/Loss**
- ☐ Yes ☐ No **Wear glasses or contacts**
- ☐ Yes ☐ No **Itchy/watery eyes**
- ☐ Yes ☐ No **Dental problems**

Other:_____

Gastrointestinal
- ☐ Yes ☐ No **Nausea /Vomiting**
- ☐ Yes ☐ No **Difficulty swallowing**
- ☐ Yes ☐ No **Hemorrhoids**
- ☐ Yes ☐ No **Diarrhea**
- ☐ Yes ☐ No **Constipation**
- ☐ Yes ☐ No **Bloody or Black Stools**
- ☐ Yes ☐ No **Abdominal pain**
- ☐ Yes ☐ No **Heart burn/indigestion**
- ☐ Yes ☐ No **Frequent use of Laxatives**

Other:_____

Urinary
- ☐ Yes ☐ No **Pain or burning with urination**
- ☐ Yes ☐ No **Urinary frequency (Night or Day)**
- ☐ Yes ☐ No **Blood in urine / Dark urine**
- ☐ Yes ☐ No **Incontinence**
- ☐ Yes ☐ No **Slow starting or stopping urine**

Other:_____

Genital/Sex Organs
- ☐ Yes ☐ No **Penile discharge**
- ☐ Yes ☐ No **Testicular lump/pain**
- ☐ Yes ☐ No **Breast Pain/discharge/lump**
- ☐ Yes ☐ No **Painful intercourse**
- ☐ Yes ☐ No **Lack of sexual desire**
- ☐ Yes ☐ No **Problems with performance**

Other:_____

FEMALE Reproductive
- ☐ Yes ☐ No **Hot Flashes**
- ☐ Yes ☐ No **Bleeding after menopause**
- ☐ Yes ☐ No **Excessive menstrual bleeding**
- ☐ Yes ☐ No **Unusual vaginal discharge**

Age at onset of menstruation_____
1st day of last menstruation_____
- ☐ Yes ☐ No Menstrual pain/cramps
- ☐ Yes ☐ No Spotting between periods

Last pap smear:_____
Results:_____
Total Pregnancies:_____
Total live births:_____
Total miscarriages:_____
Total abortions:_____
Total C-sections:_____

Cardiac
- ☐ Yes ☐ No **Chest pain**
- ☐ Yes ☐ No **Palpitation**
- ☐ Yes ☐ No **Irregular heartbeat**
- ☐ Yes ☐ No **Exercise intolerance**
- ☐ Yes ☐ No **Leg swelling**

Other:_____

Respiratory
- ☐ Yes ☐ No **Persistent Cough**
- ☐ Yes ☐ No **Coughing up blood**
- ☐ Yes ☐ No **Shortness of breath**
- ☐ Yes ☐ No **Wheezing**
- ☐ Yes ☐ No **Can't breathe laying flat**

Other:_____

Skin
- ☐ Yes ☐ No **Rashes/Hives**
- ☐ Yes ☐ No **Skin discoloration**
- ☐ Yes ☐ No **Lesions/moles/warts**
- ☐ Yes ☐ No **Ulcers**
- ☐ Yes ☐ No **Itching**
- ☐ Yes ☐ No **Nail Problems**
- ☐ Yes ☐ No **Unusual Hair loss**
- ☐ Yes ☐ No **Easy bruising**

Other:_____

Psych
- ☐ Yes ☐ No **Depressed mood**
- ☐ Yes ☐ No **Suicidal thoughts/plans**
- ☐ Yes ☐ No **Agitation/irritability**
- ☐ Yes ☐ No **Insomnia**
- ☐ Yes ☐ No **Anxiety**
- ☐ Yes ☐ No **Frequent crying spells**

Other:_____

Musculoskeletal
- ☐ Yes ☐ No **Joint pains or stiffness**
- ☐ Yes ☐ No **Joint swelling**
- ☐ Yes ☐ No **Muscle weakness**
- ☐ Yes ☐ No **Back pain**
- ☐ Yes ☐ No **Muscle spasms/cramps**
- ☐ Yes ☐ No **Falling**

Other:_____

Neurologic
- ☐ Yes ☐ No **Frequent Headache**
- ☐ Yes ☐ No **Seizures**
- ☐ Yes ☐ No **Syncope (passing out)**
- ☐ Yes ☐ No **Limb weakness**
- ☐ Yes ☐ No **Limb numbness**
- ☐ Yes ☐ No **Dizziness**
- ☐ Yes ☐ No **Swallowing difficulty**
- ☐ Yes ☐ No **Balance issues**
- ☐ Yes ☐ No **Tremors**
- ☐ Yes ☐ No **Rigidity**

Other:_____
_____
_____