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

Today's date: ______/______/______

PERSONAL INFORMATION

Name: ______________________________
Last First M.I.

Home Address: ______________________________
Street Address Apt # City State Zip Code

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)

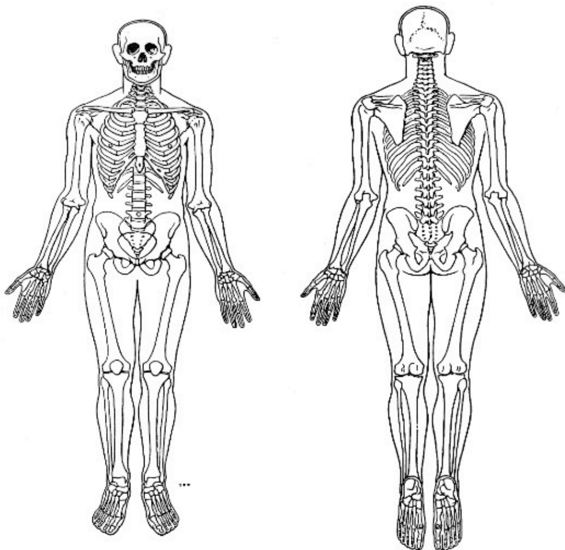
URINARY
___Pain on urination
___Increased frequency
___Frequent infections
___Kidney stones
___Inability to hold urine
___Frequency at night
___Blood in urine
___Sexually transmitted infection

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.

____
____
____
____
____
____
____