The Center for Natural Medicine, Inc.
1330 SE Cesar E. Chavez Blvd, Portland, OR 97214 | 503-232-1100 | Fax 503-232-7751 | www.cnm-inc.com

ADULT MEDICAL HISTORY

Patient Information

TODAY'S DATE: _____

Legal name: Last _____ First _____ MI ____ Preferred Name _____ Birthdate _____

Legal sex _____ Gender _____ Pronouns _____

Primary care provider _____ PCP phone # _____

Preferred pharmacy and location: _____

What are your main reasons for coming to the clinic today: *Please note priority.* ☐ Establish primary care

_____

_____

_____

_____

_____

Allergies, medications, & supplements

Allergies	Allergen	Reaction	Severity	Age	Epi pen?
☐ No known allergies					☐
					☐
					☐
					☐

Medications	Name	Dose	Frequency	Reason
☐ None				
☐ See attached				

Do you use regularly: ☐ Tylenol/acetaminophen ☐ Advil/ibuprofen ☐ Aleve/naproxen ☐ Aspirin ☐ Oral contraceptive pills

Supplements/vitamins	Name & Brand	Dose	Frequency	Reason

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Medical History

Please take a minute to think about your health throughout your life. List all known illnesses/diagnosis, major events (surgeries, hospitalizations, accidents) and imaging. If applicable, include providers name and contact information.

Diagnosis	Date	Specialist Name	Clinic Contact

Major events: surgeries, hospitalizations, accidents	Date	Imaging (x-ray, MRI, CT, ultrasound, ECG, echo, etc)	Clinic Contact

Preventative Health Care

Screening tests	Date	Results
Annual physical		
PAP (cervical / anal)		
HPV co-testing with PAP		
Mammogram		
Colonoscopy		
PSA/prostate exam		
Bone density scan		
Cholesterol		
Hepatitis C screening		
Dental exam		
Eye exam		
Diabetic foot exam		

Vaccine	Date
TDaP / Tetanus	
Seasonal influenza	
Pneumonia	
Shingles / Chickenpox	
Hepatitis A	
Hepatitis B	
Human Papillomavirus	
Other vaccine	
Other vaccine	

Did you receive standard childhood vaccines? _____
(polio, measles, mumps, rubella, tetanus, diphtheria, whooping cough)

Family Health History

Relationship	Age if living	Age of death	Medical history
Mother			
Maternal grandmother			
Maternal grandfather			
Father			
Paternal grandmother			
Paternal grandfather			
Sibling			
Child			

Did any other family members (aunts, uncles, cousins) have COLON CANCER OR COLON POLYPS: _____

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Social History

What is your living situation? _____ Are you able to care for yourself? _____
Do you live alone? _____ Do you have stable housing? _____ Do you have pets? _____
What is your occupation? _____ ☐ Student ☐ Retired ☐ Disabled ☐ None
Highest level of schooling? _____
What are your hobbies? _____
What are your religious or spiritual beliefs? _____
Do you exercise? ☐ Yes ☐ No Please specify: _____
Is stress a major problem for you? ☐ Yes ☐ No ☐ Unsure
Do you feel you have enough support from friends and family ☐ Yes ☐ No
Do you have an advanced directive? ☐ Yes ☐ No

Tobacco, alcohol, & drug use

Tobacco use ☐ Never ☐ Current ☐ Past ☐ Passive (around smoke)
If ever, what kinds? ☐ Cigarettes ☐ Cigars ☐ E-cigarettes ☐ Chew ☐ Snuff
# of cigarettes per day _____ # of years smoked _____ Quit date _____

Alcohol intake ☐ Never ☐ Current ☐ Past
How many years have you consumed alcohol? _____
# of drinks weekly _____ Quit date _____

Recreational drugs ☐ Never ☐ Current ☐ Past
How often did/do you use? _____ Quit date _____
If ever, what kinds? ☐ Cannabis ☐ Hallucinogens ☐ Cocaine
☐ Methamphetamines ☐ Opioids ☐ Benzodiazepines ☐ Other
Have you ever injected drugs? ☐ Yes ☐ No

Relationship status

Check all that apply: ☐ Single ☐ Married ☐ Partner ☐ Long-term ☐ Monogamous ☐ Open relationship

Sexual history

What is your sexual orientation? ☐ Heterosexual ☐ Lesbian, gay ☐ Bisexual ☐ Other _____

Have you ever had sex with another person? ☐ Yes ☐ No
If yes:
Are you currently sexually active? ☐ Yes ☐ No
In your lifetime, you have had sex with people with ☐ Penis ☐ Vagina ☐ Both
Do you use safer sex practices? ☐ Yes ☐ No If yes, please specify: _____
Do you or any of your partners use birth control? ☐ Yes ☐ No If yes, which kinds? _____
Are you interested in birth control counseling today? ☐ Yes ☐ No
Have you ever tested positive for an STI? ☐ Yes ☐ No If yes, which one(s)? _____
Any concerns about sexual function? ☐ Yes ☐ No
If yes, do you want to talk about it? ☐ Yes ☐ No
Have you experienced domestic or sexual violence? ☐ Yes ☐ No
If yes, do you want to talk about it? ☐ Yes ☐ No

Dietary History

Do you follow a specific diet or avoid any foods? _____

Breakfast: _____ Snacks: _____

Lunch: _____ Beverages: _____

Dinner: _____ Water total amount: _____ Caffeine: _____

Safety screening

Do you wear seatbelts?	☐ Yes ☐ No	Do you ever feel unsteady or off balance?	☐ Yes ☐ No
Do you use helmets?	☐ Yes ☐ No	Have you fallen in the past year?	☐ Yes ☐ No
Do you have access to adequate food?	☐ Yes ☐ No	Are you exposed to any toxins?	☐ Yes ☐ No
Do you feel physically safe?	☐ Yes ☐ No	Are there any guns in your home?	☐ Yes ☐ No
Do you wear sunscreen?	☐ Yes ☐ No	Smoke/carbon monoxide detectors in home?	☐ Yes ☐ No

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Review of Systems: Please check C for current and recent symptoms. Check P for symptoms you have had in the past.

System	C	P	Symptoms	C	P	Symptoms	C	P	Symptoms	Comments
General & Endocrine	☐	☐	Fatigue	☐	☐	Recent weight gain	☐	☐	Chills	
	☐	☐	Decreased appetite	☐	☐	Feels too cold/hot	☐	☐	Increased thirst	
	☐	☐	Recent weight loss	☐	☐	Fever	☐	☐	Recent foreign travel	
Eyes, Ears, Nose, Mouth, Throat	☐	☐	Wear corrective lens	☐	☐	Ear plugging	☐	☐	Bleeding gums	
	☐	☐	Blind spots	☐	☐	Vertigo	☐	☐	Dental problems	
	☐	☐	Double vision	☐	☐	Snoring	☐	☐	Swelling in neck	
	☐	☐	Eye pain	☐	☐	Sinus congestion	☐	☐	Pain in neck	
	☐	☐	Hearing loss	☐	☐	Bloody noses	☐	☐	Difficulty swallowing	
	☐	☐	Tinnitus/ringing	☐	☐	Face pain/pressure	☐	☐	Sore throat	
	☐	☐	Ear pain	☐	☐	Mouth pain	☐	☐	Sleep apnea	Date of sleep study? _____
Head	☐	☐	Headache	☐	☐	Head injury				Date of head injury?
	☐	☐	Migraine	☐	☐	Loss of consciousness				
Neurology	☐	☐	Change in memory	☐	☐	Seizures	☐	☐	Numbness	
	☐	☐	Change in speech	☐	☐	Spasms/twitches	☐	☐	Tingling	
	☐	☐	Change in walking	☐	☐	Tremors	☐	☐	Weakness	
Heart, Vascular	☐	☐	Chest pain	☐	☐	Lightheadedness	☐	☐	Rheumatic fever	Last echocardiogram?
	☐	☐	Palpitations	☐	☐	Cold fingers/toes	☐	☐	Decreased stamina	Last ECG?
	☐	☐	Heart murmur	☐	☐	Leg swelling				Can you walk up 2 flights of stairs?
	☐	☐	Fainting	☐	☐	Varicose veins				
Lungs	☐	☐	Shortness of breath	☐	☐	Wheezing	☐	☐	Difficulty lying flat	Last spirometry?
	☐	☐	Coughing	☐	☐	Bloody cough	☐	☐	Asthma	Have you had COVID-19?
Digestive	☐	☐	Abdominal pain	☐	☐	Excess gas/burping	☐	☐	Dark tarry stool	# of bowel movements daily?
	☐	☐	Heartburn	☐	☐	Diarrhea	☐	☐	Mucus in stool	Stool consistency: ☐ Varied
	☐	☐	Nausea/vomiting	☐	☐	Constipation	☐	☐	Parasitic infection	☐ Watery ☐ Soft ☐ Formed
	☐	☐	Bloating	☐	☐	Blood in stool	☐	☐	Hemorrhoids	☐ Compacted ☐ Pebbles
Urinary	☐	☐	Increased urination	☐	☐	Pain with urination	☐	☐	Slowed stream	
	☐	☐	Urgent urination	☐	☐	History of stones	☐	☐	Wait for urine	
	☐	☐	Urine leakage	☐	☐	Incomplete emptying	☐	☐	Urinate > 2x nightly	
Reproductive (mark those that apply)	☐	☐	Decreased libido	☐	☐	Irregular cycle	☐	☐	Vaginal pain	Age at first period: _____
	☐	☐	Hernia	☐	☐	Spotting	☐	☐	Pelvic pain	Last menstrual period: _____
	☐	☐	Testicular injury	☐	☐	Heavy bleeding	☐	☐	Pain with penetration	Length between periods: _____
	☐	☐	Testicular mass	☐	☐	Heavy cramping	☐	☐	Hot flashes	Age of menopause: _____
	☐	☐	Testicular self exam	☐	☐	Infertility	☐	☐	Night sweats	Number of pregnancies: _____
	☐	☐	Penis pain	☐	☐	Vaginal itching/burning	☐	☐	Abnormal PAP or HPV	
	☐	☐	Penis discharge	☐	☐	Vaginal discharge/odor	☐	☐	Genital lesions	
	☐	☐	Erectile dysfunction	☐	☐	Vaginal dryness				
Breast	☐	☐	Breast pain	☐	☐	Breast skin changes	☐	☐	Nipple discharge	
	☐	☐	Breast mass	☐	☐	Breast dimpling	☐	☐	Breast self-exams	
Blood, Lymph, Immune	☐	☐	Easy bleeding	☐	☐	Clotting problems	☐	☐	Swollen lymph nodes	
	☐	☐	Easy bruising	☐	☐	History of transfusion	☐	☐	Frequent illnesses	
	☐	☐	Iron deficiency	☐	☐	Allergies	☐	☐	Chronic infections	
Skin, Hair, Nails	☐	☐	Jaundice	☐	☐	Rash	☐	☐	Hair loss	Do you see a dermatologist?
	☐	☐	Skin wounds	☐	☐	Itching	☐	☐	Nail changes	○ Yes ○ No
	☐	☐	Changing moles	☐	☐	Eczema	☐	☐	Psoriasis	
Mental Health	☐	☐	Depression	☐	☐	Psychosis/mania	☐	☐	Suicidal ideations	Do you see a counselor?
	☐	☐	Anxiety	☐	☐	Insomnia	☐	☐	PTSD	○ Yes ○ No
	☐	☐	Panic Attacks	☐	☐	Paranoia	☐	☐	Eating disorder	
Muscles, Bones	☐	☐	Joint pain	☐	☐	Muscle cramps	☐	☐	Difficulty moving	Are you in pain? ○ Yes ○ No
	☐	☐	Joint stiffness	☐	☐	Back pain	☐	☐	Difficulty walking	Severity of pain (1-10) N/A
	☐	☐	Muscle pain	☐	☐	Neck pain				

Brief health screen

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Patient name: _____

Date of birth: _____

Alcohol: One drink = 

12 oz. beer


5 oz. wine


1.5 oz. liquor (one shot)

How many times in the past year have you had **4** or more drinks in a day? _____

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? _____

Mood:

	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○