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: _________

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

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

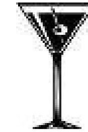
System	C	P	Symptoms	C	P	Symptoms	C	P	Symptoms	Comments
General & Endocrine	☐ ☐ ☐	☐ ☐ ☐	Fatigue Decreased appetite Recent weight loss	☐ ☐ ☐	☐ ☐ ☐	Recent weight gain Feels too cold/hot Fever	☐ ☐ ☐	☐ ☐ ☐	Chills Increased thirst Recent foreign travel	
Eyes, Ears, Nose, Mouth, Throat	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐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

Annual questionnaire

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: ____________________

Date of birth: ____________________

Alcohol: One drink = 12 beer oz. 5wine oz.  1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: 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).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical 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?	○	○