Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

11900 SW Greenburg Rd
Tigard, OR 97223

Phone: (503) 620-5556
Fax: (503) 624-0118

New Patient Adult Intake Form

Name: _____ Today's Date: _____

Date of birth: _____ Legal sex: ☐ Male ☐ Female SSN: _____

Gender: ☐ Woman ☐ Man ☐ Trans-Woman ☐ Trans-Man ☐ Non-binary ☐ Genderqueer ☐ Agender
☐ Not listed: _____

Sex Assigned at Birth: ☐ Male ☐ Female

Preferred language: _____ Phone number: _____
Is it okay to leave a detailed message concerning your appointment? ☐ Yes ☐ No
You may receive email communication about the clinic or clinic related news.

Please list any health concerns that you have at this time: _____
_____

1. Are you ☐ Single ☐ Married ☐ Partnered ☐ Divorced or Separated ☐ Widowed ☐ Other: _____
2. Where did you grow up? _____
3. What kind of work do you do or, if retired, what did you do? _____
4. What level of education did you complete? _____
5. When was the last time you were seen by a primary care physician? _____
6. Do you have an Advance Directive or Living Will? ☐ Yes ☐ No
7. Do you have a POLST (Physician Order for Life Sustaining Treatment)? ☐ Yes ☐ No

Allergies

8. Have you ever had any allergic reaction (bad effect) to a medication or shot? ☐ No ☐ Yes

   Please write the name of the medicine or shot and the effect you had: _____
9. Do you get a significant allergic reaction (bad effect) from anything else? ☐ No, I have no allergies.

   ☐ Yes, please list: _____

Medicines

10. Please list any prescription medications or supplements that you have been prescribed and/or are currently taking
    ☐ I do not take any prescription medicines
    ☐ I brought my pill bottles or a list **OR**

List your medicines below: Pharmacy: _____

Medicine or Supplement name	Strength or amount	How many pills do you take?			
EXAMPLE: ***Furosemide***	***20mg***	***2*** morning	***1*** noon	***1*** dinner	***2*** bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed

Medical History

12. Have you ever had any of the following health problems? *Check all that apply.*

- ☐ Abnormal pap test
- ☐ Allergies
- ☐ Anemia (low iron, low blood count)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer (type: _____)
- ☐ Cataracts
- ☐ Congestive heart failure (CHF)
- ☐ Bowel disorder
- ☐ Clotting disorder
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Depression (feeling low or blue)
- ☐ Diabetes (high blood sugar)
- ☐ Emphysema (lung disease)
- ☐ GERD (heartburn, acid reflux)
- ☐ Glaucoma
- ☐ Gout (joint pain in toes)
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heart attack
- ☐ Heart murmur (extra noise heart makes)
- ☐ Hepatitis (disease that affects the liver)
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Jaundice (skin and eyes turn yellow)
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Meningitis
- ☐ Osteoporosis (weak bones)
- ☐ Prostate problems
- ☐ Seizures
- ☐ Sexually transmitted disease
- ☐ Shingles (painful skin rash)
- ☐ Sickle cell (disorder affecting red blood cells)
- ☐ Skin problems
- ☐ Stroke
- ☐ Substance abuse (illegal drugs, drug problem)
- ☐ Thyroid disease
- ☐ Tuberculosis (TB, lung disease)
- ☐ Ulcers (open sores)
- ☐ Urinary problems (problem peeing)

Surgical History

13. Have you ever had surgery? ☐ No, I have never had surgery. ☐ Yes. Please list each surgery below.

Surgery	Date

Family Planning

14. Do you have sex with ☐ Men ☐ Women ☐ Both ☐ I don't have sex

If you use birth control, what type do you use? *Check all that apply.*

- ☐ Birth control pill, patch or ring
- ☐ Condom
- ☐ Cervical cap/Diaphragm
- ☐ Cycle tracking/Fertility awareness
- ☐ Injection (depo)
- ☐ Inserts
- ☐ Implant
- ☐ IUD
- ☐ Postmenopausal/Hysterectomy
- ☐ Same sex partner(s)
- ☐ Spermicide/pH Modulator
- ☐ Tubal Ligation (tubes tied)
- ☐ Vasectomy
- ☐ Withdrawal (pull out method)
- ☐ Other: _____

15. If applicable: How many times have you been pregnant? _____ How many deliveries? _____

Family History

16. Have any of your family members ever had any of the following health problems? *Check all that apply.*

	Name	Alive?	No known history	Cancer	Diabetes	Heart Problems	High Blood Pressure	High Cholesterol	Mental Illness	Stroke	Thyroid Disease	Other
Mother												
Father												
Sister												
Sister												
Brother												
Brother												

Exercise

17. Do you exercise 2 or more days a week? ☐ Yes ☐ No

Specialty Services

18. Are you currently seeing any other doctors?

Doctor's name: _____ Type of doctor: _____

When last seen: _____ Phone number: _____

Doctor's name: _____ Type of doctor: _____

When last seen: _____ Phone number: _____

Doctor's name: _____ Type of doctor: _____

When last seen: _____ Phone number: _____

Anything else we should know? _____

_____

_____

_____

_____

Symptom Review

18. Please rate current symptoms below that apply during the PAST TWO WEEKS.
Do not mark if symptoms aren't present. However if you do, rate symptoms: **1** = Mild, **2** = Moderate, **3** = Severe

Head and face			
Headaches	1	2	3
Allergies	1	2	3
Memory Loss	1	2	3
Other:	1	2	3
Eyes			
Poor vision	1	2	3
Eye pain	1	2	3
Inflammation	1	2	3
Other:	1	2	3
Ears			
Poor Hearing	1	2	3
Earaches	1	2	3
Discharge	1	2	3
Ringing	1	2	3
Other:	1	2	3
Nose			
Frequent Colds	1	2	3
Sinus Trouble	1	2	3
Bleeding	1	2	3
Difficulty Breathing	1	2	3
Other:	1	2	3
Mouth			
Gum Problems	1	2	3
Teeth Problems	1	2	3
Jaw Problems	1	2	3
Unusual Tastes	1	2	3
Other:	1	2	3
Throat			
Sore Throat	1	2	3
Hoarseness	1	2	3
Difficulty Swallowing	1	2	3
Other:	1	2	3
Body Pain			
Arthritis/Rheumatoid	1	2	3
Muscle Pain	1	2	3
Difficulty lying flat	1	2	3
Tightness in chest	1	2	3
Other:	1	2	3
Energy			
Low (fatigue)	1	2	3
High	1	2	3

Circulation			
Palpitation	1	2	3
High blood pressure	1	2	3
Low blood pressure	1	2	3
Bruise easily	1	2	3
Bleed easily	1	2	3
Slow Wound Healing	1	2	3
Cold Limbs	1	2	3
Other:	1	2	3
Gastrointestinal			
Excess thirst	1	2	3
Excess appetite	1	2	3
Weight gain or loss	1	2	3
Digestive pain	1	2	3
Nausea	1	2	3
Vomiting	1	2	3
Diarrhea	1	2	3
Constipation	1	2	3
Blood in stool	1	2	3
Colon problems	1	2	3
Hemorrhoids	1	2	3
Other:	1	2	3
Urination			
Frequent	1	2	3
Difficulty	1	2	3
Nighttime	1	2	3
Bleeding	1	2	3
Painful	1	2	3
Describe:	1	2	3
Skin			
Rashes	1	2	3
Dryness	1	2	3
Moles or lumps	1	2	3
Excess sweat	1	2	3
Night sweat	1	2	3
Rarely sweat	1	2	3
Other:	1	2	3
Sleep			
Insomnia	1	2	3
Drowsiness	1	2	3
Dream Disturbance	1	2	3
Describe:	1	2	3

Neurological			
Dizziness	1	2	3
Nervousness	1	2	3
Tremors	1	2	3
Seizures	1	2	3
Numbness/tingling	1	2	3
Loss of balance	1	2	3
Nerve pain	1	2	3
Other:	1	2	3
Women's Health			
Pelvic pain	1	2	3
Menopausal sx	1	2	3
Vagina discharge	1	2	3
Difficulty conceiving	1	2	3
Sexual difficulties	1	2	3
Other:	1	2	3
Number of pregnancies:			
Number of children:			
Menstrual Cycle			
Irregular	1	2	3
Excess blood	1	2	3
Lack of blood	1	2	3
Dark colored blood	1	2	3
Light colored blood	1	2	3
Bleeding mid-cycle	1	2	3
Clotting	1	2	3
Water retention	1	2	3
Breast tenderness	1	2	3
Emotional changes	1	2	3
Painful (cramping)	1	2	3
Mental Health			
Depression	1	2	3
Anxiety	1	2	3
Irritability	1	2	3
Other:	1	2	3
Men's Health			
Prostate problems	1	2	3
Genital pain	1	2	3
Genital swelling	1	2	3
Sexual difficulties	1	2	3
Other:	1	2	3

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Release of Records - Authorization to Disclose Protected Information

I do hereby consent and authorize Southwest Family Physicians to release or request copies of my medical records.

Patient name: _____ Date of birth: _____

Patient phone number: _____

REQUEST RECORDS FROM	RELEASE RECORDS TO
Facility name: _____	Facility name: _____
Address: _____	Address: _____
_____	_____
Phone number: _____	Phone number: _____
Fax number: _____	Fax number: _____

Please select the purpose for your request:

☐ Continuity ☐ Transfer of care ☐ Disability ☐ Insurance ☐ Legal ☐ Other: _____

This authorization shall begin immediately and remain in effect for not more than 180 days from today's date unless another date is specified.

Please select the specific information that applies to your request.

☐ Most recent 5 year history
☐ Clinical chart notes
☐ Prenatal/OB notes
☐ Other: _____
☐ Records related to (specific dates, conditions, etc.) _____
☐ Laboratory/Pathology
☐ Diagnostic Imaging Reports
☐ Immunizations

If the information to be disclosed or requested contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed or requested if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS _____Genetic testing _____ Mental health _____ Drug/alcohol information

Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care service or reimbursement for services. I understand I may revoke this authorization in writing at any time. The only exception is when information has already been released in response to this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

Patient signature (or authorized individual): _____ Date: _____

If signed by another person, indicate relationship: _____

PLEASE DO NOT SEND MEDICAL RECORDS BY CD - WE DO NOT ACCEPT THIS FORM OF RECORDS.

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Release of Information

Instructions: Fill in the name of any person(s) to allow Southwest Family Physicians to discuss your medical information with them.

I, _____, with date of birth, _____, give the providers and office staff of Southwest Family Physicians permission to discuss my medical condition with the listed person(s) below. Southwest Family Physicians may disclose health care information regarding testing, diagnosis and treatment for the following conditions:

Please **initial** the information you want disclosed:

_____ Information relating to my medical treatment

_____ Psychiatric disorders/Mental health

_____ Alcohol/Substance abuse

_____ Sexually Transmitted Diseases/HIV

_____ All other health information

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Note: This authorization does NOT allow for the sharing of copies from the patient's health record. If there is an anticipated need for copies of the patient's health record, our standard form must be completed and submitted to the medical records department.

The consent will be considered valid for 2 years or until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Patient name: _____ Date of birth: _____

Signature: _____ Today's date: _____

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Prescription Policy

Since the advent of pharmacy automated prescription refills, our office receives an ever increasing volume of calls and faxes daily for medications refill requests. We cannot safely manage this volume of phone and faxed medication requests and still provide you with the quality of care you deserve.

1. Before you come to your appointment, you should look over your medications, diabetes supplies, inhalers, etc. to determine if you need to request any new prescriptions while you are here at your face to face appointment.
2. We do require office visits on a regular basis for all of our patients taking prescription medication. The interval will vary, depending on the type of medication prescribed, how sick or stable your condition is, and what is agreed upon between you and your provider when you are here. **Please be sure you have enough medication to last until your next scheduled visit.**
3. Please bring all your prescription bottles with you to your appointment or a list including name of medication, dose, how often you take the medication, and the prescribing provider. This is important to make sure we cross-check that you are taking the correct medications and the correct doses. We will continue to take time to carefully review your medication and write enough refills at your office visit. We will also ask you to review the new prescriptions to make sure that they are written correctly.
4. We offer the following options for your in office, face to face prescription refills:
    - We can send most prescriptions electronically to most local pharmacies.
    - We can send prescriptions electronically to a mail-order pharmacy. You need to already have an account set up with the mail-order pharmacy for us to do this.
    - We can provide written prescriptions.
    - Prescriptions for certain narcotics, mental health medications, including those for attention deficit disorder medication must be printed and hand signed, as it is required by law.
5. Please plan your prescription needs in advance: prescription refill requests should not be coming to us over the phone and fax, unless there is some urgent exception. All refills will be reviewed, discussed, and refilled face to face. In the event of a rare exception, refills may take up to **2 business days**. If it is a prescription that must be hand signed and picked up at the office it may take up to **4 business days or longer**, should your provider be out of the office.
6. If you call to request a refill, but are overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in just enough medication to a local pharmacy to last until we are able to schedule an office visit. **It is your responsibility to schedule an appointment before you run out of medication.**

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7. We understand that there might be a situation when you do have to call us for a prescription. Check the list below and see what you can do to avoid incurring a prescription refill fees at the pharmacy.
    - **Are you changing to a new local pharmacy?** You should call your new pharmacy and request that your prescriptions be transferred from your old pharmacy. We sometimes do not have to write new prescriptions.
    - **Are you going on an extended vacation and need to use an out-of-town pharmacy?** You need to call the NEW pharmacy that you will be using and have them contact your hometown pharmacy to have your prescription transferred. When you return home, you have to reverse the process.
    - **Are you changing to a new mail order pharmacy?** Some pharmacies will transfer prescriptions to the new pharmacy. If you still have refills on your current prescriptions, please check with your current mail order pharmacy to see if your prescriptions can be transferred.

Thank you for choosing Southwest Family Physicians as your provider. We look forward to working with you to assure safe and high quality medical care.

By signing below, I hereby confirm that I have thoroughly read, understand and consent to the terms outlined in this document.

Patient Name: _____ Date of birth: _____

Signature: _____ Today's date: _____

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Name: _____ Date of birth: _____

Social Determinants of Health

Living Situation

1. **What is your living situation today?**

- [ ] I have a steady place to live
- [ ] I have a place to live today, but I am worried about losing it in the future
- [ ] I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**
CHOOSE ALL THAT APPLY.

- [ ] Pests such as bugs, ants, or mice
- [ ] Mold
- [ ] Lead paint or pipes
- [ ] Lack of heat
- [ ] Oven or stove not working
- [ ] Smoke detectors missing or not working
- [ ] Water leaks
- [ ] None of the above

Food

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**

- [ ] Often true
- [ ] Sometimes true
- [ ] Never true

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**

- [ ] Often true
- [ ] Sometimes true
- [ ] Never true

Transportation

5. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**

- [ ] Yes
- [ ] No

Utilities

6. **In the past 12 months has the electric, gas, oil or water company threatened to shut off services in your home?**

- [ ] Yes
- [ ] No
- [ ] Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health, we are asking the following questions.

7. How often does anyone, including family and friends, physically hurt you?

- ☐ Never (1)
- ☐ Rarely (2)
- ☐ Sometimes (3)
- ☐ Fairly often (4)
- ☐ Frequently (5)

8. How often does anyone, including family and friends, insult or talk down to you?

- ☐ Never (1)
- ☐ Rarely (2)
- ☐ Sometimes (3)
- ☐ Fairly often (4)
- ☐ Frequently (5)

9. How often does anyone, including family and friends, threaten you with harm?

- ☐ Never (1)
- ☐ Rarely (2)
- ☐ Sometimes (3)
- ☐ Fairly often (4)
- ☐ Frequently (5)

10. How often does anyone, including family and friends, scream or curse at you?

- ☐ Never (1)
- ☐ Rarely (2)
- ☐ Sometimes (3)
- ☐ Fairly often (4)
- ☐ Frequently (5)

Financial Strain

11. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- ☐ Very hard
- ☐ Somewhat hard
- ☐ Not hard at all

Employment

12. Do you want help finding or keeping work?

- ☐ Yes, help finding work
- ☐ Yes, help keeping work
- ☐ I do not need or want help

Family and Community Support

13. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?

- ☐ I don't need any help
- ☐ I get all the help I need
- ☐ I could use a little more help
- ☐ I need a lot more help

14. How often do you feel lonely or isolated from those around you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Education

15. Do you speak a language other than English at home?

☐ Yes ☐ No

16. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent?

☐ Yes ☐ No

Physical Activity

17. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

☐ 0 days ☐ 1 day ☐ 2 days
☐ 3 days ☐ 4 days ☐ 5 days
☐ 6 days ☐ 7 days

18. On average, how many minutes did you usually spend exercising at this level on one of those days?

☐ 0 minutes ☐ 10 minutes ☐ 20 minutes
☐ 30 minutes ☐ 40 minutes ☐ 50 minutes
☐ 90 minutes ☐ 120 minutes ☐ 150 minutes or greater

Substance Use

The next questions relate to your experience with alcohol, cigarettes and other drugs. Some of the substances are prescribed by a doctor (like pain medications), but only count those if you have taken them for a reason or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask in order to identify community services that may be available to help you.

19. How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

☐ Never ☐ Once or twice ☐ Monthly
☐ Weekly ☐ Daily or almost daily

20. How many times in the past 12 months have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarettes)?

☐ Never ☐ Once or twice ☐ Monthly
☐ Weekly ☐ Daily or almost daily

21. How many times in the past year have you used prescription drugs for non-medical reasons?

☐ Never ☐ Once or twice ☐ Monthly
☐ Weekly ☐ Daily or almost daily

22. How many times in the past year have you used illegal drugs?

- [ ] Never
- [ ] Once or twice
- [ ] Monthly
- [ ] Weekly
- [ ] Daily or almost daily

Mental Health

23. Over the past 2 weeks, how often have you been bothered by any of the following problems?

a) Little interest or pleasure in doing things?

- [ ] Not at all (0)
- [ ] Several days (1)
- [ ] More than half the days (2)
- [ ] Nearly everyday or everyday (3)

b) Feeling down, depressed, or hopeless?

- [ ] Not at all (0)
- [ ] Several days (1)
- [ ] More than half the days (2)
- [ ] Nearly everyday or everyday (3)

24. Stress means a situation in which a person feels tense, restless, nervous, anxious or is unable to sleep at night because their mind is troubled all the time. Do you feel this kind of stress these days?

- [ ] Not at all
- [ ] A little bit
- [ ] Somewhat
- [ ] Quite a bit
- [ ] Very much

Disabilities

25. Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?

- [ ] Yes
- [ ] No

26. Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- [ ] Yes
- [ ] No