Pacific Integrative Oncology

1471 Pearl Street, Suite 2 ⋄ Eugene, OR 97401 ⋄ (541)338-9494

PATIENT DEMOGRAPHICS

Name: _____ Date of Birth: _____ Age: _____
First MI Last

Street Address: _____ City: _____

State: _____ Zip code: _____ Gender: _____ Home Phone: _____

Cell Phone: _____ How did you hear about us? _____

Email: _____

Occupation: _____ ▢ Full time ▢ Part Time ▢ Retired ▢ Student

Emergency contact: _____ Phone: _____ Relation: _____

INSURANCE INFORMATION

Carrier: _____ Subscriber ID: _____

Group #: _____ Naturopathic Coverage? (Y/N) _____ Copay: _____

MEDICAL HISTORY

What are your most important health care problems? Please list in order of importance to you.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Pacific Integrative Oncology

1471 Pearl Street, Suite 2 ⋄ Eugene, OR 97401 ⋄ (541)338-9494

MEDICAL HISTORY CONT.

Are you currently under the care of a Primary Care Physician? ▢ YES ▢ NO
If yes, what is the name of your Provider? _____
Office Location? _____

Are you currently under the care of any additional Specialists/Oncologists? If so, whom?

_____

Please list current medications and over-the-counter drugs you are taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Do you have any drug or environmental allergies?

_____
_____

Please list current supplements and herbs you are taking, with dose, if possible:

_____
_____
_____
_____

Please list any major accidents, head injuries, falls, blows, etc:

_____
_____
_____

Pacific Integrative Oncology

1471 Pearl Street, Suite 2 ⋄ Eugene, OR 97401 ⋄ (541)338-9494

MEDICAL HISTORY CONT.

Hospitalizations and Surgery (include transfusions, x-rays, cat scans, etc):

_____
_____
_____
_____

Is there any additional information you would like us to know?

_____
_____
_____
_____

FAMILY HISTORY

Relation:	Living/Deceased:	Age:	Major Illnesses or Cause of Death:
Mother			
Father			
Brother(s)			
Sister(s)			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Pacific Integrative Oncology

1471 Pearl Street, Suite 2 ⋄ Eugene, OR 97401 ⋄ (541)338-9494

Please check any of the following that have occured in your blood relatives

▢ Heart Disease	▢ Stroke	▢ Neurological Disorders
▢ Kidney Disease	▢ Glaucoma	▢ Suicide
▢ Seizures	▢ Mental Illness	▢ Depression
▢ Hypertension	▢ Alcoholism	▢ Thyroid Disease
▢ Drug abuse	▢ Sexually Transmitted Disease	▢ Cancer
▢ Miscarriage	▢ Tuberculosis	

Birth and Development History

Did your mother have any problems during pregnancy? _____
Problems during labor and delivery? _____
Was there any delay in your walking or talking? _____

Childhood Illness (please check all you have had)

▢ Rubella	▢ Measles	▢ Whooping Cough	▢ Scarlet Fever
▢ Rheumatic Fever	▢ Mumps	▢ Chickenpox	▢ Polio

Immunization History (please check all you have had)

▢ DPT	▢ Smallpox	▢ Polio	▢ Measles/Mumps/Rubella	▢ Tuberculosis
▢ Hepatitis B	▢ Pneumonia	▢ Hib	▢ Chickenpox	

Did you have any reactions following your immunizations? ▢ Yes ▢ No
If so, what? _____

Pacific Integrative Oncology

1471 Pearl Street, Suite 2 ⋄ Eugene, OR 97401 ⋄ (541)338-9494

REVIEW OF SYMPTOMS

GENERAL

Weight: _____ Weight 1 year ago _____
Maximum Weight: _____ When? _____
Height _____

Circle the correct response for the following:
Y = A condition you have now **P =** a condition you have had in the past **N =** a condition you have never had

SKIN
Rashes Y P N
Eczema Y P N
Acne,boils Y P N
Moles Y P N
Itching Y P N
Color Change Y P N
Lumps Y P N
Night Sweats Y P N

HEAD
Headaches Y P N
Head Injury Y P N

EYES
Impaired vision Y P N
Glasses or contacts Y P N
Eye pain Y P N
Tearing or dryness Y P N
Double vision Y P N
Glaucoma Y P N
Cataracts Y P N

EARS
Impaired hearing Y P N
Ringing Y P N
Earaches Y P N
Dizziness Y P N

MOUTH &THROAT
Frequent sore throat Y P N
Sore tongue Y P N
Gum problems Y P N
Hoarseness Y P N
Dental cavities Y P N

NECK
Lumps Y P N
Swollen glands Y P N
Goiter Y P N
Pain or stiffness Y P N

RESPIRATORY
Cough Y P N
Sputum Y P N
Spitting up blood Y P N
Wheezing Y P N
Asthma Y P N
Chronic bronchitis Y P N
Pneumonia Y P N
Pleurisy Y P N
Emphysema Y P N
Pain on breathing Y P N
Shortness of breath Y P N
Tuberculosis Y P N

CARDIOVASCULAR
Heart disease Y P N
Angina Y P N
High blood pressure Y P N
Murmurs Y P N
Rheumatic fever Y P N
Chest pain Y P N
Swelling in ankles Y P N
Palpitations Y P N

GASTROINTESTINAL
Trouble swallowing Y P N
Heartburn Y P N
Change in thirst Y P N
Change in appetite Y P N
Nausea/vomiting Y P N
Blood in stool Y P N
Belching/passing gas Y P N
Jaundice Y P N
Liver disease Y P N
Gall bladder disease Y P N
Ulcer Y P N
Hemorrhoids Y P N

Pacific Integrative Oncology

1471 Pearl Street, Suite 2 ⋄ Eugene, OR 97401 ⋄ (541)338-9494

Circle the correct response for the following:

Y = A condition you have now **P =** a condition you have had in the past **N =** a condition you have never had

NOSE & SINUSES

Frequent colds Y P N
Stuffiness Y P N
Nose bleeds Y P N

MUSCULOSKELETAL

Joint pain Y P N
Arthritis Y P N
Broken bones Y P N
Muscle spasms/cramps Y P N

BLOOD

Anemia Y P N
Easy bleeding Y P N

URINARY

Painful urination Y P N
Increased frequency Y P N
Frequency at night Y P N
Inability to hold urine Y P N
Frequent infections Y P N
Kidney stones Y P N

MALE REPRODUCTIVE

Hernias Y P N
Testicular masses Y P N
Testicular pain Y P N
Prostate disease Y P N
Venereal disease Y P N

PERIPHERAL VASCULAR

Deep leg pain Y P N
Cold hands/feet Y P N
Varicose veins Y P N
Thrombophlebitis Y P N

ENDOCRINE

Hypothyroid Y P N
Heat or cold intolerance Y P N
Excessive thirst Y P N
Excessive hunger Y P N

DO YOU…

Exercise? Yes No
Eat three meals per day? Yes No
Average 6-8 hours of sleep per night? Yes No
Use recreational drugs? Yes No
Use tobacco products? Yes No
Drink alcoholic beverages? Yes No

Pacific Integrative Oncology

1471 Pearl Street, Suite 2 ⋄ Eugene, OR 97401 ⋄ (541)338-9494

FEMALE REPRODUCTIVE HISTORY

MENSES

Age menses began: _____ Date of last period: _____ Regular Periods? ▢ YES ▢ NO
Length of cycle: _____ Flow: ▢ Heavy ▢ Medium ▢ Light Duration: _____
Spotting: ▢ YES ▢ NO Mid-cycle: ▢ YES ▢ NO Instead of periods: ▢ YES ▢ NO
Bloating: ▢ YES ▢ NO Weight gain: ▢ YES ▢ NO If yes, how much? _____ LBS
Cramps: ▢ YES ▢ NO Duration: _____ days Intensity: Mild Moderate Severe
PMS: ▢ YES ▢ NO Describe symptoms: _____

PELVIC EXAM

Date of last pelvic exam: _____ Reason: _____
Date of last Pap: _____ Results: _____
Previously abnormal Pap? ▢ YES ▢ NO If yes, give dates, results and therapy: _____
Reoccuring vaginal yeast infections? ▢ YES ▢ NO Onset: _____ Frequency: _____
Vaginal discharge? ▢ YES ▢ NO If yes, please describe: _____
Venereal disease? ▢ YES ▢ NO If yes, please describe: _____
Are you sexually active? ▢ YES ▢ NO Sexual difficulties? ▢ YES ▢ NO
Sexual orientation: ▢ Heterosexual ▢ Bisexual ▢ Homosexual

BREAST EXAM

Breast pain/lumps: ▢ YES ▢ NO Nipple discharge? ▢ YES ▢ NO
Date of last mammogram: _____ Results: _____
Do you do monthly self-breast exam? ▢ YES ▢ NO

HORMONES

Ovaries present? ▢ YES ▢ NO Uterus present? ▢ YES ▢ NO Are you menopausal? ▢ YES ▢ NO
Have you already undergone menopause? ▢ YES ▢ NO If yes, when/age: _____
Hot flashes: ▢ YES ▢ NO Vaginal dryness: ▢ YES ▢ NO Painful intercourse: ▢ YES ▢ NO

PREGNANCY

Are you currently pregnant? ▢ YES ▢ NO Planning: ▢ YES ▢ NO Number of pregnancies? _____
Number of live births: _____ Number of miscarriages: _____ Birth control: ▢ YES ▢ NO