OHSUHealth
Hillsboro Medical Center

Label

NEW PATIENT QUESTIONNAIRE

NAME: ____ DATE OF BIRTH: _____/_____/_____

REASON FOR VISIT: ______________________________________ TODAY'S DATE: _____/_____/______

MEDICATIONS:

Please list the medications you are taking (prescription, over-the-counter, and supplements). Complete the column for dosage and mark the box for how often you are taking each medication. Attach additional pages if needed.

Medication Name	Dosage	How often you are taking?
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ as needed

ALLERGIES:

If you have any new allergies, please list them below:

☐ None	☐ Latex
☐ Antibiotics (*please specify below)*	☐ Egg
☐ X-ray/Radiology Contrast	☐ Other (*please specify below)*

____

____

FAMILY HISTORY

Have your blood relatives had any of the following? *If yes,please mark the box for their relation to you*.

Colon Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Colon Polyps	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Esophageal Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Crohn's Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Liver Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Pancreatic Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Stomach Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Ulcerative Colitis	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Gallbladder Problems	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Breast Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Ovarian Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Uterine Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent

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PAST ENDOSCOPIC HISTORY:

Have you had any of the following endoscopies? *If the answer is yes, please mark the box, and complete the additional spaces.*

Type of Endoscopy	When	Did they fnd Ployps
☐ Colonoscopy/Lower scope		☐ Yes ☐ No
☐ EGD/Upper scope		

Have you had a problem with sedation or anesthesia? (describe)

____

____

HISTORY OF VACCINATIONS:

Please mark the box if you have had the following vaccinations:

☐ Hepatitis A	☐ Pneumovax (Pneumonia)
☐ Hepatitis B	☐ Flu Shot (for this season)

PAST MEDICAL HISTORY:

Have you EVER experienced any of the following? *If the answer is yes, please mark the box.*

☐ Anemia	☐ Heart Attack	☐ Kidney Disease
☐ Anxiety Disorder	☐ Heart Failure	☐ Liver Disease
☐ Artificial Joints	☐ Heart Murmur	☐ Pacemaker
☐ Asthma	☐ Heart Valve Replacement	☐ Pancreatitis
☐ Bleeding Disorder	☐ Hepatitis	☐ Rheumatic Fever
☐ Colon Polyps	☐ Hiatal Hernia	☐ Seizure Disorder
☐ Colon/Rectal Cancer	☐ High Blood Pressure	☐ Sleep Disorder
☐ COPD/Emphysema	☐ High Cholesterol	☐ Stomach Cancer
☐ Crohn's Disease	☐ History of Tuberculosis	☐ Stroke
☐ Depression	☐ History of Blood Clots	☐ Tattoos
☐ Diabetes	☐ HIV Infection	☐ Thyroid Disorders
☐ Diverticulosis	☐ Implantable Defibrillator	☐ Ulcerative Colitis
☐ Diverticulitis	☐ Implantable Stimulator	☐ Using Home Oxygen
☐ Frequent Bladder Infection	☐ Irritable Bowel Syndrome	

PAST SURGICAL HISTORY:

Have you had any of the following surgeries? *If the answer is yes, please mark the box.*

☐ Appendix Removal	☐ Heart Surgery	☐ Portion of Bowel Removal
☐ Gallbladder Removal	☐ Hysterectomy	☐ Stomach Surgery

Please list any additional surgeries:

____

____

Signature: ____ Date: ______________