KIRKPATRICK
FAMILY CARE

1706 Washington Way
Longview, WA 98632
(360) 423-9580

Primary Care Provider (Check the box):
RAK ☐ RLB ☐ IAS ☐ VJM☐
KUT☐ GGK☐ MG☐

First Appointment Date: _______________
Today's Date: _______________

BACKGROUND:

Name: ______________________________ Birth Date: ____________________

Weight: ____________________ How long have you been at this weight: ____________________

Height: ____________________ Waist Size: ______________________________

What is the main reason you came to the doctor at this time? ______________________________

____

INDUSTRIAL HISTORY:

Are you working? Yes ☐ No ☐ If yes, what do you do? ______________________________

Are you ever exposed to the following substances at work?

☐ Chemicals ☐ Ash ☐ Fiberglass
☐ Dust ☐ Asbestos ☐ Other: ____________________

SOCIAL HISTORY:

Are you Married? Yes ☐ No ☐

If so, when were you married? ______________________________

Do you have any previous marriages? Yes ☐ No ☐

If so, what was their duration? ______________________________

Do you currently smoke, have you ever smoked, or have you been exposed to second-hand smoke? Yes ☐ No ☐

If yes, please describe usage and/or exposure: ______________________________

Do you chew tobacco? Yes ☐ No

If yes, please describe usage: ______________________________

Do you drink caffeinated beverages? Yes ☐ No ☐

If yes, please describe usage: ______________________________

Do you drink alcohol? Yes ☐ No ☐

If yes, please describe the type and amount below:

☐ Beer ________per day / week / month
☐ Wine ________per day / week / month
☐ Mixed Drinks ________per day / week / month

How do you use salt?

☐ Excessively ☐ Barely
☐ Normally ☐ None

FAMILY HISTORY:

Please indicate the following:

Family Member	Alive (Yes / No)	Age(s) (or at Death)	Health Now (or Cause of Death)
Father			
Mother			
Spouse			
Sister(s)			
Brother(s)			
Children			

Please indicate the illnesses/conditions that have occurred in any of your blood relatives:

Condition	Yes	No	Additional Information *(including which blood relative had this condition)*
Allergies			
Arthritis			
Asthma			
Bleeding Tendency			
Cancer			
Diabetes			
Gallstones			
Heart Disease			
High Cholesterol			
High Blood Pressure			
Kidney Disease			
Nervous Disorders			
Strokes			
Tuberculosis			
Other			

MEDICAL HISTORY:

Please indicate the illnesses/conditions that you have had:

Condition	Yes	No	Additional Information
Allergies			
Arthritis			
Asthma			
Bleeding Tendency			
Cancer			
Cold Sores			
Diabetes			
Gallstones			
Glaucoma			
Gonorrhea			
Heart Disease			
Herpes			
High Cholesterol			
High Blood Pressure			
Jaundice			
Kidney Disease			
Nervous Disorders			
Parasites			
Pneumonia			
Rheumatic Fever			
Syphilis			
Strokes			
Tuberculosis			
Vein Trouble			
Other Unusual Conditions			

Please list all your childhood illnesses:

____

____

____

Have you ever had any major injuries, broken bones, etc.? *Yes* ☐ *No* ☐

If yes, what and when: ____

____

____

Please list all previous operations:

Operation	Date	Hospital	Surgeon

Please list all illnesses or conditions not requiring operation for which you were hospitalized:

Problem	Year	Hospital

Have you traveled outside North America? Yes ☐ No ☐ If yes, where and when? ______________________

Did you get sick? Yes ☐ No ☐ If yes, please describe: ____

Please list all medications you are currently taking, including any herbal, mineral or vitamin supplements:

Name	Dose	How Often

Have you had an allergic reaction or side effect to any medications or substances? Yes ☐ No ☐

If so, please list the medication and/or substance, and describe your reaction:

____

____

____

Have you ever had a blood transfusion? Yes ☐ No ☐ If so, when? ____________________________

Have you ever used cortisone-type medications (skin cream, inhalers, etc.)? Yes ☐ No ☐

RECENT PROCEDURE HISTORY:

Please fill in the dates of the last time you have had the following procedures:

Procedure	**Date**
Chest X-ray	
EKG	
Check-up	
Blood Count	
Pap Smear *(females)*	
Mammogram *(females)*	
PSA *(males)*	
Colonoscopy	

ADVANCED DIRECTIVE:

Has an Advanced Directive been explained to you? Yes ☐ No ☐

If yes, do you have one? Yes ☐ No ☐

If you are interested in learning more about what an Advanced Directive is and how to obtain one, please ask your nurse as he/she checks you in.

REVIEW OF SYSTEMS:

Constitutional:

	Yes	No
Do you have sweats at night?		
Do you have persistent cough or hoarseness?		
Do you have unusual bleeding or discharge?		
Do you have a sore that won't heal?		
Do you have any change in a wart or mole?		
Do you have any change in bowel habits?		
Do you have unexplained fever or weight loss?		

Eyes, Ears, Nose & Throat:

	Yes	No
Do you have trouble with your vision?		
Has a doctor ever said you have glaucoma?		
Do you have difficulty hearing?		
Do you have buzzing or ringing in your ears?		
Are you often dizzy?		
Do you have frequent nosebleeds?		
Do you often have head colds?		
Do you have sinus trouble?		
Have you had bleeding gums in the past year?		
Has your voice been persistently hoarse in the past year?		
Is your tongue often sore?		

Cardiovascular:

	Yes	No
Do you often have chest pain?		
Do you have chest pressure or tightness when excited?		
Do you have chest pressure or tightness when walking or working?		
Does your heart often thump or race?		
Are our feet or legs unusually swollen by the end of the day?		
Has a doctor ever said that you have heart trouble?		

Respiratory:

	Yes	No
Do you have a cough almost every day?		
Do you regularly cough up phlegm or sputum?		
Have you coughed up blood in the past year?		
Do you have frequent chest colds?		
Have you had pneumonia or severe bronchitis in the past year?		
Has a doctor ever said you have emphysema?		
Have you had asthma in the past year?		
Are you unusually short of breath when walking or working?		

Endocrine:

	Yes	No
Have you had a change in your voice?		
Have you had a change in hair or skin texture?		
Are you hungry all the time?		
Are you thirsty all the time?		
Do you have frequent urination?		
Have you taken any hormone shots or pills in the past year?		
Have you taken any thyroid medication in the past year?		
Have you taken insulin or other diabetes medication in the past year?		
Have you taken any cortisone or similar medication in the past year?		

Please fill-out if applicable to you:

Are you usually hot or cold? ___________________________________

Have you had recent weight loss or weight gain? __________________

Are bowel movements usually constipated or loose? _______________

Do you feel jittery or sluggish? _________________________________

Gastrointestinal:

	Yes	No
Do you often have a poor appetite?		
Do you have trouble swallowing food or liquid?		
Do you have indigestion or heartburn?		
Do you often have stomach trouble?		
Do you have excessive gas or bloating?		
Have you bled from the rectum in the past year?		
Do you have trouble with constipation?		
Do you have diarrhea frequently?		
Do you have hemorrhoids?		
Do you often have itching around the rectum?		
Has a doctor ever told you that you have a stomach or duodenal ulcer?		
Has a doctor ever said you have gallbladder trouble?		
Has a doctor ever said you have jaundice?		

Genitourinary:

	Yes	No
Do you get up more than once from sleep to urinate?		
Do you have burning pain with urination?		
Do you often have trouble starting urination?		
Have you had blood in the urine in the past year?		
Do you have trouble emptying your bladder completely?		
Have you ever passed a kidney stone?		
How many urinary tract infections have you been treated for in the past year?		

Neurologic:

	Yes	No
Do you get bad headaches?		
Do you have fainting or blackout spells?		
Have you ever had a convulsion?		
Have you ever been paralyzed?		
Do you often have numbness of the hands?		
Do you often have numbness of the feet?		

Gynecological: *(Women only)*

	Yes	No
Do you have vaginal discharge or itching?		
Do you have excessive menstrual cramps, pain or bloating?		
Do you have excessive menstrual bleeding or spotting?		
Are you taking birth control pills or female hormones?		
Have you missed a period or had a late period?		
Are you pregnant, or think you might be?		
If you are past menopause, have you had any vaginal spotting or bleeding?		
Do you have hot flashes frequently?		
Do you have excessive breast tenderness?		
Do you have regularly check for breast lumps?		
Have you had breast lumps?		

Menstrual History:

When was your last period? ______________________________

Are you periods? ☐ Regular ☐ Irregular

Number of Pregnancies: ______________________________

Number of Miscarriages: ______________________________

Musculoskeletal:

	Yes	No
Do you often have back pain?		
Do your hands turn purple or white in the cold?		
Does sunlight cause a facial rash?		
Do you get “catches” in your back?		
Do you have rheumatism or arthritis?		
Has a doctor ever said that you have gout?		
Has a doctor ever said that you have fibrositis?		
Do your joints ever feel hot or swollen?		

Psychological:

	Yes	No
Do you have trouble sleeping?		
Have you ever had a nervous breakdown?		
Do you often feel discouraged or depressed?		
Do you frequently feel nervous, worried, or upset?		
Do you cry often?		
Do you lose your temper often?		
Have you considered suicide?		
Have you seen a counselor or thought you should?		
Have you ever used cocaine?		
Have you ever used marijuana?		
Have you ever used LSD?		
Have you ever used heroin?		
Have you ever used methamphetamines or speed?		
Have you ever been addicted?		
Do you drink alcohol to excess?		

Please rate your:

	Good	Average	Poor
Family Life			
Sex Life			
Marriage			
Job			
General Happiness			

Hemodynamic:

	Yes	No
Do you get large bruises on your skin?		
Have you ever bled excessively or hemorrhaged?		
Have you been treated for anemia in the past year?		
Have you had a fever in the past month?		
Do you often have skin rashes?		
Do you have severe acne?		
Do you get frequent fungus infections?		

Pharmacological:
In the past year, have you taken any of the following?

	Yes	No
Medicine for fluid retention?		
Medicine to try to lose weight?		
Medicine for high blood pressure?		
Heart medicine?		
Iron or blood-building medicine?		
Sedatives?		
Sleeping pills?		
“Pep” pills?		
Ointments for skin trouble?		
Stomach or digestion medicine?		
Laxatives or enemas (other than for x-rays or other medical procedures)?		
Frequent use of aspirin or pain medicine?		

Thank you. We appreciate your taking the time to complete this thorough questionnaire. It will help us to consider your entire health history in diagnosing and treating your current symptoms.