

❖ **NEW PATIENT PROFILE**

Please complete these pages as accurately and as completely as possible. If you need help, please ask. If possible, *please use a blue ink pen to make your form easier to read.*

Today's date: _____ / _____ / _____

Name: _____ Gender: Male Female
FIRST MIDDLE LAST

Date of birth: _____ / _____ / _____ Current age: _____ Height: _____ Weight: _____

Home street address: _____

City: _____ State: _____ Zip code: _____

Mailing address (if preferred): _____

City, state, zip code _____

Home phone: (_____) _____ OK to leave 'medical' message? Yes No

Work phone: (_____) _____ OK to leave 'medical' message? Yes No

Mobile phone: (_____) _____ OK to leave 'medical' message? Yes No

E-mail: _____ OK to leave 'medical' message? Yes No

Occupation: _____ Employer: _____

Emergency contact: _____ Phone: (_____) _____

❖ **HEALTH INFORMATION—confidential**

PRESENT HEALTH CONCERNS: *Please list your most important health concerns. If possible, please list them in order of importance to you. For example, #1 is most important, and #5 is least important.*

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

YOUR MAJOR GOALS FOR THE FIRST VISIT: *Please tell me what you would like to accomplish on the first visit.*

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

YOUR QUESTIONS: *What questions do you have for today's visit?* _____

ALLERGIES: *Please list all food, environmental, and/or drug allergies:* _____

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Current prescription medications (e.g., Prozac, atenolol, etc), **non-prescription medications** (e.g., aspirin, Tylenol, ibuprofen) and/or **health supplements** (e.g., vitamins, minerals, herbs): *Please list the medications and/or supplements that you are currently taking. **Please also list any drug allergies.***

NAME of medication or supplement—drugs, vitamins, herbs, minerals	DOSE in milligrams or grams (or number of capsules, tablets)	FREQUENCY: Times per day/ week/ month	DURATION: Been taking for how long?

MOST RECENT VISIT TO A DOCTOR: *When was the last time you consulted a doctor, and for what reason?* _____

Date of last complete physical exam: _____

Date of most recent lab/blood tests: _____

WOMEN—date of last PAP smear: ____ results:_____ Currently pregnant? YES NO UNSURE

Medical procedures, hospitalizations, major injuries, and serious illnesses: *Please list previous medical procedures, surgeries, hospitalizations, and serious illnesses.*

Approximate date/ year	Surgery/ hospitalizations/ procedure/ serious illnesses/ injuries

DIET: *Do you follow any particular diet regimens or restrictions?* _____

EXERCISE: *Do you exercise regularly? If YES—what do you do? If NO—what keeps you from exercising?* _____

HABITS and LIFESTYLE: *Please circle or list which of the following you use:* tobacco/cigarettes alcohol coffee black tea cola/soda aspirin/Tylenol/analgesics antacids recreational drugs prescription drugs *Other:* _____

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❖ MUTUAL UNDERSTANDINGS AND CONSENT TO TREATMENT

The following information is provided to enable our sharing of a common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have understood and agreed to the following. Please ask any questions if you would like clarification or additional information.

- ◆ Information revealed during counseling sessions and office visits is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so. Dr Vasquez is happy to work with your other healthcare providers; physicians are often in contact with each other regarding the care of patients who are under the care of multiple physicians (i.e., “co-managed”) and this communication does not require consent by the patient. Although Dr Vasquez co-manages with other physicians and clinicians, Dr Vasquez is not responsible for their actions or lack of action; Dr Vasquez works as an independent contractor in the UWS Clinics (eg, Gresham Integrated Care, Columbia Integrated Care) and neither the UWS Clinics nor UWS have any responsibility for the care provided by Dr Vasquez. Although Dr Vasquez has several doctorate-level healthcare degrees and has been licensed in other state at other times, he currently practices exclusively via his Oregon naturopathic license.
- ◆ Each procedure and/or treatment carries with it both risks and benefits. There may be additional or alternative treatments available. You are encouraged to ask questions if you would like additional information. Although your plan will be thoroughly researched and will be customized to your unique health status and your personal goals, no guarantees can be assured regarding the outcomes of treatment(s) or procedure(s). If you are prescribed medications, you should read the information that accompanies any prescription items; consult with the dispensing pharmacist to ensure that you understand how to take the medicine and which—if any—adverse effects might occur. Only take medications that you are comfortable taking based on the potential risks and benefits.
- ◆ Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered. Treatments, consultations (whether by phone, e-mail, or in the office), detailed correspondence on your behalf are examples of professional services. You are responsible for payment for office fees, treatments, and lab tests regardless of insurance coverage. At your request, you will receive a detailed receipt to request reimbursement from your insurance carrier. Dr Vasquez does not bill or affiliate with Medicare/Medicaid or other so-called health insurance companies, and Medicare/Medicaid does not reimburse for lab tests, nutrition consultation, and preventive medicine regardless of your need for these services.
- ◆ When you call and schedule an appointment, time is reserved especially for you and no one else. We therefore require a prepaid deposit which is applied toward your visit, labs, and treatments and which is forfeited if you cancel your appointment without giving us 24-hour notice.
- ◆ Because of his teaching, traveling, and research schedule, Dr. Vasquez is not available on a 24-hour basis at all times. You need to have another doctor with whom you can consult in the event of an emergency or urgent problem. If you have a serious health problem that requires immediate attention, you should call your other doctors(s), call 911, or have someone take you to the nearest hospital emergency room. If you notice an adverse effect from one of the components of your health plan, you should discontinue it then email (preferred: dralexvasquez@gmail.com) or call (503.432.5341) Dr. Vasquez and inform him of what occurred.
- ◆ Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Please let Dr. Vasquez know if you are being treated by other healthcare providers (physicians, counselors, therapists, etc.). Consult your prescribing doctor before discontinuing medications. It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments between visits.
- ◆ You are welcome to bring a friend or relative to your visits if such companionship is comfortable for you.
- ◆ You are encouraged to ask questions on any health-related topic and to take an active role in your health-care. Ours is a team approach, and natural treatments may involve encouraging you to make changes in your diet and lifestyle that can help you attain your highest level of health.

The contact information, health history, and other information that I provided on my intake form are complete and accurate. I understand and agree to the information on this page. My questions, if any, were answered to my satisfaction.

SIGNATURE of patient or guardian

Date

Name:	Today's date:
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REVIEW OF SYSTEMS: I have designed the following form so that it will be easy for you to complete. Simply check the appropriate box for each attribute so that we can further discuss the specific areas of concern that you have—if you have additional comments or want to provide additional information, please make a note and we can discuss your concerns during the visit. Please provide additional information where you mark the answer "Yes→." Your completing this form will enable us to work more efficiently during our time together and will allow a means by which to reassess your status on future visits.

GENERAL HEALTH	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Fatigue, lack of energy, lack of stamina	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Need to decrease or alter activities of daily living due to fatigue, pain, or illness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Insomnia, lack of sleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Excessive tiredness and increased need for sleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Tired and/or not hungry after waking	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain at night, night sweats	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Enlarged lymph nodes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Frequent infections	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Undesired weight loss	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Undesired weight gain, difficulty losing weight	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Cold hands or feet	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Compulsive/binge eating, increased appetite	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Decreased appetite	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Hypoglycemia, low blood sugar	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Allergies to food or environment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sensitivity to fumes, chemicals, odors, exhaust	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Have you been tested for iron disorders?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> ?	
Past diagnosis of serious illness or chronic health condition such a systemic disease, cancer, HIV, mental condition, heart disease, infection, kidney problems, or other condition	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
MUSCLES and JOINTS	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Pain, swelling, or limited motion in joint(s)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain, swelling, or weakness in muscle(s)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Cramps in muscles, grind teeth at night?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other problem, concerns, or questions in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
HEAD and MIND	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Headaches	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling of pressure inside head	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Faintness, loss of consciousness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Dizziness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Seizures, epilepsy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Difficulty thinking or processing information; confusion	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Difficulty with concentrating or maintaining attention	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Poor memory	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Difficulty speaking or talking, slurred speech	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Hyperactivity	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Learning difficulties, dyslexia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other problem, concern, or question in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		

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EMOTIONS and SOCIAL HEALTH	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Depression, sadness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Anger, irritability, anxiety	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Stressful situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Apathy, lack of interest or concern	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Use of alcohol, herbs, drugs, or medications to help manage emotions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Isolation, few friends, distant family	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Problems with parents or family	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Problems with employer(s) or coworker(s)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sadness or recurrent problems from childhood or past events	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Recent or current thoughts of suicide?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
Diagnosed mental condition such as bipolar, schizophrenia, or other condition	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
Other problem, concern, or question in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
EYES	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Watery, red, or itchy eyes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Dark circles under eyes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Decrease or loss of vision; cataracts, or glaucoma	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Poor night vision, night blindness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain in eye(s)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain near or behind eye(s)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other problem, concern, or question in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
EARS	Very rare- None	Occasional- -Mild	Intermittent- -Moderate	Frequent- Severe
Earaches, pain in ear(s)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Ringing in ear(s)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Ear infections	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Decrease or loss of hearing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other problem, concern, or question in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
MOUTH, NOSE, and THROAT	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Swollen or tender tongue or gums	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Decreased sense of taste or smell	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Stuffy nose, nasal congestion	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sinus infections, sinus pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Nasal polyps	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Ulcers or sores in mouth or lips, oral herpes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Allergies/ sneezing/ runny nose	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Excessive mucus formation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Drainage to back of throat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sore throat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Cough or wheeze	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Change in voice	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Hoarseness, loss of voice	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other problem, concern, or question in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		

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LUNGS and HEART	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Pain in left arm and/or left side of neck or face	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Shortness of breath, difficulty breathing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Irregular heartbeat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Rapid or pounding heartbeat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Chest congestion, bronchitis	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Asthma	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Medications for lungs or heart	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Current or past cigarette smoking or tobacco use	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain in chest	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
High blood pressure, high cholesterol, or high triglycerides?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
Other problem, concern, or question in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
SKIN, HAIR, and NAILS	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Acne	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Eczema	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Psoriasis	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Dry skin	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Oily skin	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Flushing, hot flashes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Itchy skin (with or without redness) or hives	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Decrease in body or facial hair	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Decrease in head hair (not male pattern baldness)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Increase in body or facial hair	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Excessive sweating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Insufficient sweating when hot or active	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Area(s) of numbness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Area(s) of tingling	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Area(s) of pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Weak or ridged fingernails	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Change in skin color or pigmentation, vitiligo	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Small rough bumps on back of upper arms	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Other problem, concerns, or questions in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
STOMACH and DIGESTIVE TRACT	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Heartburn	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Poor digestion	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Nausea	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Vomiting	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Diarrhea	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Constipation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Belching, intestinal bloating, gas or flatulence	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain in stomach, intestines, colon	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Rectal itching, pain, or bleeding	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Hemorrhoids	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Loss of bowel control, incontinence	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other problem, concern, or question in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		

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KIDNEYS and GENITALS	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Kidney stones	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other kidney problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Difficulty controlling urination, incontinence	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Bladder problems (other than infections)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Frequent urination	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain or burning with urination	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Discharge or blood in urine	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Urinary tract (kidney, bladder, urethra) infection(s)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sexually transmitted disease(s)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Genital herpes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Low sex drive, low libido	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Have you been tested for HIV?	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Not tested	
Other problem, concern, or question in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
For WOMEN only—HORMONAL STATUS and SEXUAL FUNCTION	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Irregular menses	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Painful menses	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain between menses	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Painful, swollen, or fibrocystic breasts	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Water retention	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Premenstrual syndrome	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Excessive bleeding	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Abnormal uterine bleeding	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
Missed menses	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Vaginal dryness, irritation, painful intercourse	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Yeast infections	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Uterine fibroids	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Menopausal symptoms or concerns	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
Infertility	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Annual Pap smear, breast examination, and health checkup?	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Family history of breast, uterine, or ovarian cancer	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
Other problem, injury, concern in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
For MEN only—HORMONAL STATUS and SEXUAL FUNCTION	Very rare- None	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Pain or difficulty obtaining or maintaining erection	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain or difficulty with ejaculation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain or mass in testicles	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Slow stream of urine or frequent urination	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Undescended testis, testis in abdomen or pelvis	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Men over 50: annual PSA test and prostate exam?	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Family history of prostate cancer	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		
Other problem, injury, concern in this area?	<input type="checkbox"/> NO	<input type="checkbox"/> YES→		

Additional notes or comments:

Name:	Today's date:
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Clinic appointments and location: (503) 512-1040

Gresham Integrated Care
[1304 NW Civic Drive](#)
Gresham, OR 97030

Note that the office is just a short walking distance from Portland's light-rail system: **MAX Blue Line**



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