

# WELCOME TO OUR OFFICE

**BARBARA A. GRAHAM, M.D., P.C.**

The Graham Clinic  
12672 N.W. Barnes Road Suite 100  
Portland, OR 97229  
Telephone (503) 644-7434

TODAY'S DATE \_\_\_\_\_

**Thank you for choosing our office.**

*In order to serve you properly we will need the following information. (Please print.) All information will be strictly confidential.*

Patient's name		Birth date	Marital status Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		
Residence address		City	State	Zip	Home phone
If child, parent's name or guardian's name					
Name of employer		Address			Business phone
Social security number		Driver's license		Occupation	
Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, how do you intend to pay? <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Credit card		Ins. co. name & address	
Subscriber name		Policy no.	Certificate no.	Is it through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of spouse		Birth date		Social Security number	
Is there secondary ins., spouse 2nd carrier, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name & address of spouse employer			Business phone
Secondary ins. name & address			Policy no.	Certificate no.	
Medicaid no.			Medicare no.		
Workmen's compensation			Name of company		
Address of company		Company phone		Treatment authorized by	
Person financially responsible for this account		Address			Relationship to Patient
Nearest friend or relative not residing with you			Relationship to patient		Phone
Whom may we thank for referring you?			Address		
What is your chief complaint?					

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent, or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. **Please print and complete all information.**

Case No.	Medicare No.	Medicaid No.	Today's Date	Birth date	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Last Name		First	Middle	Daytime phone		Home Phone
Address			City	State	Zip	Marital Status
Person to notify in emergency			Daytime Phone		Relationship	Last Physical Examination Date
By Doctor			Phone		Family or Referring Doctor	Phone No.

May I contact either of these Doctors for your past health records? Yes  No  What are your present medical symptoms? \_\_\_\_\_

Family History	IF LIVING		IF DECEASED		Any blood relatives who have or have had any of the listed conditions							
	HEALTH		Death Age	Death Cause	✓ Yes No Relationship			✓ Yes No Relationship				
Age	Good	Fair			Poor	✓	Yes	No	Relationship	✓	Yes	No
Father					Asthma				Hay Fever			
Mother					Arthritis				Insanity			
Brothers (Circle Sisters Sex)					Allergies				Kidney Disease			
1. M F					Anemia				Leukemia			
2. M F					Alcoholism				Migraine			
3. M F					Bleeding Tend.				Nervous Break'n			
4. M F					Cancer				Obesity			
5. M F					Colitis				Rheumatism			
Husband <input type="checkbox"/> Wife <input type="checkbox"/>					Congenital Heart				Rheumatic Fever			
Sons (circle Daughters sex)					Diabetes				Stroke			
1. M F					Epilepsy				Suicide			
2. M F					Goiter				Stomach Ulcers			
3. M F					High Bl. Press.				Tuberculosis			
4. M F					Heart Disease							
5. M F												
6. M F												

<b>HABITS</b> Do You <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Smoke <input type="checkbox"/> <input type="checkbox"/> Drink Coffee <input type="checkbox"/> <input type="checkbox"/> Drink Alcohol <input type="checkbox"/> <input type="checkbox"/> Drink Beer <input type="checkbox"/> <input type="checkbox"/> Fall Asleep Easily <input type="checkbox"/> <input type="checkbox"/> Awaken Early <input type="checkbox"/> <input type="checkbox"/>	<b>MEDICATIONS</b> ✓ If Taken Antacids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Aspirin, Bufferin, Anacin <input type="checkbox"/> Barbiturates <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Blood Pressure Pills <input type="checkbox"/>	✓ Blood Thinning Pills <input type="checkbox"/> Cortisone <input type="checkbox"/> Cough Medicine <input type="checkbox"/> Digitalis <input type="checkbox"/> Dilantin <input type="checkbox"/> Hormones <input type="checkbox"/> Insulin, Diabetic Pills <input type="checkbox"/>	✓ Iron or Poor Blood Med. <input type="checkbox"/> Laxatives <input type="checkbox"/> Phenobarbital <input type="checkbox"/> Shots <input type="checkbox"/> Sleeping Pills <input type="checkbox"/> Thyroid Med. <input type="checkbox"/> Tranquilizers <input type="checkbox"/>	✓ Vitamins <input type="checkbox"/> Water Pills <input type="checkbox"/> Weight Reducing Pills <input type="checkbox"/> Other (list) _____ _____ _____
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<b>Operations you have had:</b>	<b>Diseases you have had requiring hospitalization</b>	<b>Serious illness not requiring hospitalization</b>
Year	Year	Year
_____	_____	_____
_____	_____	_____

<b>Drugs you are allergic to:</b> _____ _____	<b>Describe any serious injuries or accidents you have had</b> _____ _____
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**WOMEN only:**  Yes  No

Are you still having regular monthly menstrual periods?

Have you ever had bleeding between your periods?   When? \_\_\_\_\_

Do you have very heavy bleeding with your periods?   When? \_\_\_\_\_

Do you feel bloated and irritable before your period?

Are you now on or have you ever taken the birth control pill?   When? \_\_\_\_\_

Have you ever had a miscarriage?   When? \_\_\_\_\_

Have you ever had a discharge from the nipple of your breast?   When? \_\_\_\_\_

Do you regularly have the cancer test of the cervix?   Date of last test \_\_\_\_\_

How many children born alive \_\_\_\_\_

How many stillbirths \_\_\_\_\_

How many premature births \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

How many miscarriages \_\_\_\_\_

How many cesarean operations \_\_\_\_\_

Any complications of pregnancy? (explain) \_\_\_\_\_

**MEN only:** Have you ever had:  Yes  No

Loss of sexual activity? For how long?

Treatment for genitals (private parts)?

Discharge from penis?

Hernia (rupture)?

Prostate trouble?

