Dr Pepel Family Practice
30250 SW Parkway Ave, Ste #9, Wilsonville, OR, 97070
Phone: (503)-232-3302, Fax: (503)-200-2895
Tax ID # 20-586-7083 NPI # 1700978178

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date________________

Patient Name____Birthdate________________

Chief Complaint____

Height___________Weight_____________________

History of present illness

Location (where is the pain/problem?)

Quality (Example: color, activity, throbbing…)

Severity (Scale 1-10 with 10=most severe)

Duration (When did it start?)

Timing (Does the problem occur at a specific time?)

Context (Where were you at the onset?)

Associated signs/ symptoms/ problems

Modifying factors (What makes it better or worse?)

Previous Hospitalizations, Surgeries, Serious Illnesses	When?	Hospital, City, State

Medications or Supplements: ____

____

____

Patient Social History

Marital Status	Single	Married	Separated	Divorced	Widowed
Use of alcohol	Never	Rarely	Moderate	Daily	
Use of tobacco	Never	Previously, but quit		Current packs/ day	
Use of drugs	Never	Type/Frequency			
Excessive exposure at home or work to	Fumes	Dust	Solvents	Noise	Air-borne Particles

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Children			

Have you ever had the following? (Past or Present Disease)

Constitutional Symptoms		**Genitourinary**		**Psychiatric**	
Good general health lately	no/yes	Frequent urination	no/yes	Memory loss	no/yes
Recent weight change	no/yes	Burning/ painful urination	no/yes	Nervousness	no/yes
Fever	no/yes	Blood in urine	no/yes	Depression	no/yes
Fatigue	no/yes	Change in force of strain	no/yes	Insomnia	no/yes
Headache	no/yes			Suicidal thoughts	no/yes

Health History Form Page 2

Eyes

Wear glasses/contact lenses no/yes
Blurred or double vision no/yes
Eye disease or injury no/yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing no/yes
Earaches or drainage no/yes
Chronic sinusitis or rhinitis no/yes
Nose bleeds no/yes
Slow to heal after cuts no/yes
Mouth sores no/yes
Bleeding gums no/yes
Bad breath or bad taste no/yes
Sore throat or voice change no/yes
Swollen glands in neck no/yes

Cardiovascular

Heart trouble no/yes
Chest pain or angina pectoris no/yes
Palpitation no/yes
Rheumatic fever no/yes
Swelling of feet, hands… no/yes
High Blood Pressure no/yes
Low Blood Pressure no/yes
Mitral Valve Prolapse no/yes

Respiratory

Cough/Throat clearing no/yes
Spitting up blood no/yes
Shortness of breath no/yes
Wheezing no/yes
Pneumonia no/yes
Asthma no/yes

Gastrointestinal

Hepatitis no/yes
Loss of appetite no/yes
Change in bowel movements no/yes
Nausea/vomiting no/yes
Frequent diarrhea no/yes
Painful bowel movements no/yes
Constipation no/yes
Rectal bleeding/blood in stool no/yes
Abdominal pain no/yes
Ulcer no/yes
Hemorrhoids no/yes

Kidney stone no/yes
Sexual difficulty no/yes
Male-testicle pain no/yes
Female-irregular periods no/yes
Female-vaginal discharge no/yes
Female # of pregnancies
Female # of miscarriage
Bladder infection no/yes
Incontinence/ dribbling no/yes
Female-date of last PAP
Female-pain with periods no/yes

Musculoskeletal

Joint pain no/yes
Joint stiffness no/yes
Joint swelling no/yes
Weakness of muscles no/yes
Weakness of joints no/yes
Muscle pain or cramps no/yes
Back pain no/yes
Cold extremities no/yes
Difficulty in walking no/yes
Arthritis no/yes

Infectious Mono no/yes

Cancer no/yes

Integumentary/ Skin/ Breast

Change in skin color no/yes
Change in hair or nails no/yes
Varicose veins no/yes
Breast pain no/yes
Rash or itching no/yes
Hives or Eczema no/yes
Bleeding tendency no/yes
Breast lump no/yes
Breast discharge no/yes

Neurological

Frequent headaches no/yes
Dizzy/ light headed no/yes
Convulsions/ seizures no/yes
Numbness/ tingling no/yes
Tremors no/yes
Paralysis no/yes
Head injury no/yes
Epilepsy no/yes
Migraine Headache no/yes
Stroke no/yes

Violent/ unusual thoughts no/yes

Endocrine

Glandular/hormone problem no/yes
Excessive thirst/urination no/yes
Heat/cold intolerance no/yes
Skin becoming dryer no/yes
Change in hat or glove size no/yes
Thyroid Disease
Diabetes no/yes

Hematologic/ Lymphatic

Anemia no/yes

Bleeding/bruising tendency no/yes
Anemia no/yes
Phlebitis no/yes
Past transfusion no/yes
Enlarged glands no/yes

Allergic/ Immunologic

History of skin reaction or other adverse reaction to:
Penicillin/ other antibiotics no/yes
Morphine, Demerol/ Narcotics no/yes
Novocain/ Anesthetics no/yes

Aspirin/ pain remedies no/yes
Tetanus antitoxin/ serums no/yes
Iodine, merthiolate, antiseptics no/yes
Other drugs/ medication_______________
____

Food allergies_________________________
____
Environmental allergies________________
____

Any other disease no/yes (Please list):

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient/ Guardian ___________________________________Date_____________________________________