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WELCOME!

Confidential Patient Information

Patient name _____ Birthdate _____ Age _____ Today's Date _____

Parents/Guardian (if a minor) _____ Spouse/Partner _____

Address _____ City/State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Occupation _____ Employer _____

Marital Status _____ Spouse/Partner's Employer _____ Phone _____

Emergency Contact Person _____ Phone _____

Relationship _____ Address _____

Insurance Co. _____ Address _____

Policy# _____ Group# _____ Policyholder _____ Birthdate _____

Assignment and Release: I hereby authorize my insurance benefits be paid directly to this physician, and I understand that I am financially responsible for non-covered services. I also authorize this physician to release any information required to process this claim.

Signature

Date

What are your top health concerns?

1) _____

2) _____

3) _____

List any medications (prescription or over the counter) and/or supplements you are taking:

List any known allergies to food, drugs or chemicals _____

Are you currently under a physician's care? _____ If yes, physician's name _____

Last physical exam _____ Last blood work _____ Last dental exam _____

Women: Last women's annual exam _____ Last menstrual period _____

Number of pregnancies _____ Birth Control history _____

Children (names & ages) _____

How did you hear about my practice? _____

(Continued on back....)

Medical History and Family History

Please write "self" or name of family member (siblings, parents, grandparents, aunts/uncles, children) next to the medical conditions you or they have suffered:

- | | | |
|--|--|---|
| <input type="checkbox"/> Abnormal PAP smear | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Menstrual disorder |
| <input type="checkbox"/> Allergies/hay fever/hives | <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heartburn/reflux | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Prostate disease |
| <input type="checkbox"/> Athletes foot | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Birth defect | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Hepatitis/liver disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast disorders | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colds, frequent | <input type="checkbox"/> Infertility | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Vaginal infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Varicose veins/blood clots |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Menopause difficulties | <input type="checkbox"/> Vertigo/dizziness |
| <input type="checkbox"/> Other _____ | | |

Major illnesses/accidents/hospitalizations/surgeries: _____

Immunizations received and any adverse reactions: _____

Health Habits

Exercise: Type & Frequency _____

Sleep: Average # of hrs _____ Quality _____

Tobacco: ___ Yes ___ No If yes, how much, how long? _____

Caffeine: ___ Yes ___ No If yes, how much, how long? _____

Alcohol: ___ Yes ___ No If yes, how much, how long? _____

Your typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____