

Patricia J. Meyer, ND 12616 SE Stark Street Portland, Oregon 97233 (503) 408-0790

UPDATED MEDICAL HISTORY

NAME:				DATE:
ADDRESS:				CITY:
STATE:	ZIP:	DATE OF E	BIRTH:	AGE:
PHONE #:			CELL #:	
EMAIL ADDRESS:				
				RED CONTACT #:
				DRESS:
				CED WIDOWED PARTNERSHIP
			_	
WHAT WAS THE REAS	SON?			
				LABS?
BIOPSYMAMMOGRAMEKG	BO	DNE DENSITY TEST LTRASOUNDU VACCINE ETNUS VACCINE		MRI PNEUMONIA VACCINE
PLEASE LIST ALL SURG	GERIES (INCLUDE DA	ATE, HOSPITAL AND R	EASON):	

PLEASE LIST ALL CURRENT MEDICATIONS, VITAMINS AND SUPPLEMENTS (INCLUDING DOSAGES) [IF YOU NEED MORE ROOM, PLEASE ATTACH A LIST AND INDICATE "SEE ATTACHED" ON THE TOP LINE]:

<u>MEDICATIONS</u>			<u>DOSAGE</u>				
PLEASE LIST ALL ALLERGIES (<u>INCLUDE</u>	DRUG, FOC	DD AND ENVI	RONMENTAL AN	ID WHAT IS THE REA	ACTION):		
ARE YOU A CURRENT/FORMER SMOK	ER?		NEVER SMOK	(ED?			
F YES, WHEN DID YOU START SMOKII	NG?		IF YOU QUIT,	WHEN DID YOU QU	JIT?		
HOW MUCH DO (DID) YOU SMOKE?_			HOW OFTEN	?			
DO YOU USE CBD OR MARIJUANA PRO	ODUCTS?	HO\	V OFTEN AND H	OW MUCH?			
DO YOU DRINK ALCOHOL?		HO\	V OFTEN AND H	OW MUCH?			
	NT WEIGHT?CURRENT HEIGHT?						
		HOW MUCH DO YOU EXERCISE?					
OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEN	ΛS?	NOT AT ALL	SEVERAL DAYS	_			
ITTLE INTEREST OR PLEASURE IN DOI EELING DOWN, DEPRESSED OR HOPI							
NSURANCE:	INCLIDED	n'S NIANAE:		DATE OF	: DIDTU:		
D#:				DATE OF			
ADDRESS:							
RELATIONSHIP TO INSURED:							
EMERGENCY CONTACT:PHONE #:				P:			
hereby authorize Patricia J. Meyer, Nall information which the insurance information may be transmitted vis factors. AND SET OVER TO DR. MEYER ALL SENEFITS.	e company acsimile ma	may reque chine or in p	st concerning nerson (do not e	ny present illness mail). I HEREBY AS	or injury. Thi		

PATIENT

DATE

INSURED/GUARDIAN

PATIENT NAME:		_ DATE:		
FAM	ILY HISTORY – PLEASE CHECK ALL THAT	Γ APPLY		
FATHER:				
LIVING AGE	AUTOIMMUNE DISEASE	HIGH BLOOD PRESSURE		
DECEASED AGE	CANCER TYPE	MENTAL ILLNESS		
CAUSE	DIABETES	NEUROLOGICAL ILLNESS		
HISTORY UNKNOWN	HEART DISEASE/STROKE	THYROID PROBLEMS		
OTHER				
MOTHER:				
LIVING AGE	AUTOIMMUNE DISEASE	HIGH BLOOD PRESSURE		
DECEASED AGE	CANCER TYPE	MENTAL ILLNESS		
CAUSE	DIABETES	NEUROLOGICAL ILLNESS		
HISTORY UNKNOWN	HEART DISEASE/STROKE	THYROID PROBLEMS		
OTHER				
PATERNAL GRANDFATHER:				
LIVING AGE	AUTOIMMUNE DISEASE	HIGH BLOOD PRESSURE		
DECEASED AGE	CANCER TYPE	MENTAL ILLNESS		
CAUSE	DIABETES	NEUROLOGICAL ILLNESS		
HISTORY UNKNOWN OTHER	HEART DISEASE/STROKE	THYROID PROBLEMS		
PATERNAL GRANDMOTHER:				
LIVING AGE	AUTOIMMUNE DISEASE	HIGH BLOOD PRESSURE		
DECEASED AGE	CANCER TYPE	MENTAL ILLNESS		
CAUSE	DIABETES	NEUROLOGICAL ILLNESS		
HISTORY UNKNOWN OTHER	HEART DISEASE/STROKE	THYROID PROBLEMS		
MATERNAL GRANDFATHER:				
LIVING AGE	AUTOIMMUNE DISEASE	HIGH BLOOD PRESSURE		
DECEASED AGE	CANCER TYPE	MENTAL ILLNESS		
CAUSE	DIABETES	NEUROLOGICAL ILLNESS		
HISTORY UNKNOWN OTHER	HEART DISEASE/STROKE	THYROID PROBLEMS		
MATERNAL GRANDMOTHER:				
LIVING AGE	AUTOIMMUNE DISEASE	HIGH BLOOD PRESSURE		
DECEASED AGE	CANCER TYPE	MENTAL ILLNESS		
CAUSE	DIABETES	NEUROLOGICAL ILLNESS		
HISTORY UNKNOWN	HEART DISEASE/STROKE	THYROID PROBLEMS		
OTHER				
BROTHER(S):				
LIVING AGE	AUTOIMMUNE DISEASE	HIGH BLOOD PRESSURE		
DECEASED AGE	CANCER TYPE	MENTAL ILLNESS		
CAUSE	DIABETES	NEUROLOGICAL ILLNESS		
HISTORY UNKNOWN	HEART DISEASE/STROKE	THYROID PROBLEMS		
OTHER				
SISTER(S):				
LIVING AGE	AUTOIMMUNE DISEASE	HIGH BLOOD PRESSURE		
DECEASED AGE	CANCER TYPE	MENTAL ILLNESS		
CAUSE	DIABETES	NEUROLOGICAL ILLNESS		
HISTORY UNKNOWN	HEART DISEASE/STROKE	THYROID PROBLEMS		

OTHER _____



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PROVIDER LIST

PATIENT NAME:		DATE:			
DO YOU HAVE A PRIMARY CARE PROVIDER?	YES	NO	IF YES, PLEASE LIST THEM FIRST		
PLEASE LIST ALL PROVID	ERS YOU SEE	(INCLUDING M	1D, DO, PA, NP, LMT, ETC.)		
NAME:					
CLINIC:					
ADDRESS:					
PHONE #:	D	ATE LAST SEEN	1:		
NAME:					
CLINIC:					
ADDRESS:					
PHONE #:	D	ATE LAST SEEN	1:		
NAME:					
CLINIC:					
ADDRESS:					
PHONE #:	D	ATE LAST SEEN	l:		
NAME:					
CLINIC:					
ADDRESS:					
PHONE #:	D	ATE LAST SEEN			
NAME:					
CLINIC:					
ADDRESS:					
PHONE #:	D	ATE LAST SEEN			
NAME:					
CLINIC:					
ADDRESS:					
PHONE #:		ATE LAST SEEN	1:		

(IF YOU NEED MORE ROOM, PLEASE ADD AN ATTACHMENT)

PATIENT NAME:	DATE	

GAD - 7

OVER THE LAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS? (Please check the appropriate boxes.)	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
For Office Coding		+	+ +	
			=Total Score	:
	•			

PATIENT NAME:	DATE:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

OVER THE LAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS? (Please check the appropriate boxes.)	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
For Office Coding		+	+ +	
			=Total Scor	e:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat Difficult Very Difficult Extremely Difficult