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 BIRTH:_____ AGE:_____

PHONE #:_____ CELL #:_____

EMAIL ADDRESS:_____

RACE:_____ ETHNICITY:_____ PREFERRED CONTACT #:_____

PREFERRED PHARMACY:_____ PHARMACY ADDRESS:_____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ PARTNERSHIP

WHEN AND WHERE DID YOU RECEIVE YOUR LAST HEALTH CARE?_____

WHAT WAS THE REASON?_____

WHEN WAS YOUR LAST *PHYSICAL* EXAM?_____ LABS?_____

HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY AND INDICATE DATE)

☐ BIOPSY_____ ☐ BONE DENSITY TEST_____ ☐ COLONOSCOPY _____

☐ MAMMOGRAM_____ ☐ ULTRASOUND_____ ☐ MRI _____

☐ EKG_____ ☐ FLU VACCINE _____ ☐ PNEUMONIA VACCINE_____

☐ SHINGLES VACCINE_____ ☐ TETNUS VACCINE _____ ☐ OTHER _____

PLEASE LIST ALL HOSPITALIZATIONS (INCLUDE DATE, HOSPITAL AND REASON):

_____

_____

_____

PLEASE LIST ALL SURGERIES (INCLUDE DATE, HOSPITAL AND REASON):

_____

_____

_____

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]:

MEDICATIONS	**DOSAGE**

PLEASE LIST ALL ALLERGIES (INCLUDE DRUG, FOOD AND ENVIRONMENTAL AND WHAT IS THE REACTION):

_____

_____

_____

ARE YOU A CURRENT/FORMER SMOKER?_____ NEVER SMOKED?_____

IF YES, WHEN DID YOU START SMOKING?_____ IF YOU QUIT, WHEN DID YOU QUIT?_____

HOW MUCH DO (DID) YOU SMOKE?_____ HOW OFTEN?_____

DO YOU USE CBD OR MARIJUANA PRODUCTS?_____ HOW OFTEN AND HOW MUCH?_____

DO YOU DRINK ALCOHOL?_____ HOW OFTEN AND HOW MUCH?_____

WHAT IS YOUR CURRENT WEIGHT?_____ CURRENT HEIGHT?_____

HOW MANY HOURS DO YOU SLEEP PER NIGHT?_____ HOW MUCH DO YOU EXERCISE?_____

OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
LITTLE INTEREST OR PLEASURE IN DOING THINGS FEELING DOWN, DEPRESSED OR HOPELESS	☐ ☐	☐ ☐	☐ ☐	☐ ☐

INSURANCE:_____ INSURED'S NAME:_____ DATE OF BIRTH:_____

ID #:_____ Group #:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

RELATIONSHIP TO INSURED:_____ INSURANCE PHONE #:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

PHONE #:_____

I hereby authorize Patricia J. Meyer, ND and Namaste Natural Healing Center, Inc. to furnish my insurance company all information which the insurance company may request concerning my present illness or injury. This information may be transmitted vis facsimile machine or in person (do not email). I HEREBY ASSIGN, TRANSFER AND SET OVER TO DR. MEYER ALL OF MY RIGHTS, TITLE, AND INTEREST TO MY MEDICAL REIMBURSEMENT BENEFITS.

_____ _____ _____

INSURED/GUARDIAN **PATIENT** **DATE**

PATIENT NAME:_____ DATE:_____

FAMILY HISTORY – PLEASE CHECK ALL THAT APPLY

FATHER:

- ☐ LIVING AGE _____
- ☐ DECEASED AGE _____
- CAUSE _____
- ☐ HISTORY UNKNOWN
- ☐ OTHER _____
- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

MOTHER:

- ☐ LIVING AGE _____
- ☐ DECEASED AGE _____
- CAUSE _____
- ☐ HISTORY UNKNOWN
- ☐ OTHER _____
- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

PATERNAL GRANDFATHER:

- ☐ LIVING AGE _____
- ☐ DECEASED AGE _____
- CAUSE _____
- ☐ HISTORY UNKNOWN
- ☐ OTHER _____
- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

PATERNAL GRANDMOTHER:

- ☐ LIVING AGE _____
- ☐ DECEASED AGE _____
- CAUSE _____
- ☐ HISTORY UNKNOWN
- ☐ OTHER _____
- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

MATERNAL GRANDFATHER:

- ☐ LIVING AGE _____
- ☐ DECEASED AGE _____
- CAUSE _____
- ☐ HISTORY UNKNOWN
- ☐ OTHER _____
- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

MATERNAL GRANDMOTHER:

- ☐ LIVING AGE _____
- ☐ DECEASED AGE _____
- CAUSE _____
- ☐ HISTORY UNKNOWN
- ☐ OTHER _____
- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

BROTHER(S):

- ☐ LIVING AGE _____
- ☐ DECEASED AGE _____
- CAUSE _____
- ☐ HISTORY UNKNOWN
- ☐ OTHER _____
- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

SISTER(S):

- ☐ LIVING AGE _____
- ☐ DECEASED AGE _____
- CAUSE _____
- ☐ HISTORY UNKNOWN
- ☐ OTHER _____
- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

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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 PROVIDERS YOU SEE (INCLUDING MD, DO, PA, NP, LMT, ETC.)

NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE #:_____DATE LAST SEEN:_____

NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE #:_____DATE LAST SEEN:_____

NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE #:_____DATE LAST SEEN:_____

NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE #:_____DATE LAST SEEN:_____

NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE #:_____DATE LAST SEEN:_____

NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE #:_____DATE LAST SEEN:_____

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

Please return these forms to Dr. Meyer by Fax or in person. Do not email.

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**
1. Feeling nervous, anxious or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
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**
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
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 Score:_____

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
☐	☐	☐	☐