Do you have any of the following? Please check all that apply.

Constitutional symptoms
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ Obesity
- ☐ Anorexia/bulimia

Eyes
- ☐ Glaucoma
- ☐ Difficulty with vision
- ☐ Other (please describe)

_____

_____

_____

Ears, Nose, Mouth and Throat
- ☐ Sinusitis
- ☐ Hearing loss
- ☐ Dizziness
- ☐ Sore throat
- ☐ Sleepy during the day
- ☐ Loud snoring at night
- ☐ Sleep apnea

Musculoskeletal
- ☐ Arthritis
- ☐ Rheumatic fever
- ☐ Joint pain
- ☐ Back problems
- ☐ Fracture/broken bones
- ☐ Other (please describe)

_____

_____

Skin/Breast
- ☐ Breast lump
- ☐ Unusual mole
- ☐ Skin rash

Neurological
- ☐ Seizures
- ☐ Multiple sclerosis
- ☐ Migraine headaches
- ☐ Fainting spells
- ☐ Stroke/TIA

Genitourinary
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Herpes
- ☐ Trouble urinating
- ☐ Sexual concerns
- ☐ Yeast infections or bladder infections

Psychiatric
- ☐ Chemical dependency
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep disorder

Endocrine
- ☐ Diabetes
- ☐ Hot or cold all the time
- ☐ Thyroid disease

Hematologic/Lymphatic
- ☐ Anemia (low blood count)
- ☐ Bleeding tendency
- ☐ Blood clots
- ☐ Blood disease
- ☐ Swelling of glands

Allergic/Immunologic
- ☐ Latex sensitivity
- ☐ HIV/AIDS
- ☐ Chicken pox
- ☐ Seasonal allergies

Cardiovascular
- ☐ Congenital heart disease
- ☐ Circulatory problems
- ☐ Pacemaker
- ☐ Heart murmur
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Elevated cholesterol
- ☐ Chest pain/pressure

Respiratory
- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Cough
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ Other (please describe)

_____

_____

Gastrointestinal
- ☐ Hepatitis (type_____)
- ☐ Liver disease
- ☐ Jaundice (yellow skin)
- ☐ Blood in stool
- ☐ Abdominal pain
- ☐ Abdominal bloating
- ☐ Recent vomiting
- ☐ Recent diarrhea
- ☐ Heartburn
- ☐ Feeling full early
- ☐ Peptic ulcer disease
- ☐ Other (please describe)

_____

_____

Oncology
- ☐ Cancer

If yes, are you receiving chemotherapy? ☐ Yes ☐ No

Seattle Premier Health
1600 E Jefferson St Suite 115
Seattle, WA 98122

Seattle Premier Health

Patient Registration

Please complete this form and return it to Seattle Premier Health at 1600 E Jefferson St, Suite 115, Seattle, WA 98122. If you prefer, you may fax it to our office at 206-215-4315. Please call 206-215-4300 with any questions.

General Information

Name (Last) _____

(First) _____ (MI) _____

Age_____ Date of birth_____/_____/_____

Place of birth _____

Height _____ Usual weight _____

Current weight _____ How long at current weight _____

Are you now or could you be pregnant? ☐ Yes ☐ No

Have you traveled outside the United States in the past five years?

☐ Yes ☐ No

If yes, where? _____

Allergies

List allergies to foods, medicines and medical products, such as tape or latex.

Allergy	Reaction

Questions/Health Concerns

Do you have any questions or health concerns we should know about, or conditions you would like evaluated?

_____

_____

_____

_____

Personal Medical History

Please list any medical problems (past or present) and the date(s) they occurred.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Date of last physical exam _____

Are you currently under medical treatment? ☐ Yes ☐ No

If yes, for _____

_____

Medications

List all prescription medications, over-the-counter drugs, supplements, herbs and vitamins you are currently taking, or have taken in the last month.

Medicati on Name	Dose (in mgs)	Frequency (times per day)	Last Dose

Do you take any of the following?

- ☐ Daily aspirin _____ mg
- ☐ Antioxidants
- ☐ Sleeping medications, tranquilizers
- ☐ Acetaminophen, ibuprofen
- ☐ Anticoagulants
- ☐ Daily calcium supplement _____ mg
- ☐ Daily vitamin D supplement or multivitamin
- ☐ Oral contraception/estrogen replacement

Surgeries and Procedures

Please list all previous surgeries and procedures.

Surgery	Year	Surgeon

Have you had serious injuries or broken bones in the past?

If yes, please list_____

Have you had blood products transfused at any time? _____

If yes, when? _____

For Women

Start date of last menstrual period _____

Periods are: ☐ Regular ☐ Irregular

Number of pregnancies _____

Number of miscarriages_____

History of abnormal Pap smear? ☐ Yes ☐ No

Have you experienced early menopause or amenorrhea? ☐ Yes ☐ No

Post-menopausal (menopause at age_____)

Take estrogen: ☐ Never ☐ Currently ☐ Past

Recent Tests and Screening Exams

Date of most recent:

Colonoscopy _____

Mammogram_____

Pap smear_____

Bone density_____

EKG

Date _____ Normal: ☐ Yes ☐ No

Cardiac stress test

Date _____ Normal: ☐ Yes ☐ No

Date of most recent test for:

Cholesterol and blood sugar levels

Total cholesterol _____

LDL cholesterol_____

Triglycerides_____

HDL cholesterol _____

Blood sugar _____

Immunizations/Date of Last Booster

Tetanus _____

Tetanus/pertussis _____

Pneumovax _____

Flu _____

Hepatitis A _____

Hepatitis B _____

German measles (rubella) _____

Measles _____

Polio _____

Varicella _____

Zostavax (shingles) _____

Human papillomavirus (HPV) _____

Other immunizations _____

Alcohol and Drug Use

Tobacco use: ☐ Never ☐ Now ☐ Past

If ever, how much each day? _____

For how many years? _____ When did you quit?_____

Alcohol use: ☐ Never ☐ Now ☐ Past

If ever, how much each day? _____

For how many years? _____ When did you quit?_____

Drug use: ☐ Never ☐ Now ☐ Past

For how many years? _____ When did you quit?_____

Caffeine use: ☐ Never ☐ Now ☐ Past

If ever, how much each day? _____

Exercise and Diet

Number of times per week you exercise:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Minutes duration for each session:

☐ 10 ☐ 15 ☐ 20 ☐ 30 ☐ 45 ☐ 60 ☐ 90

Type of activities

Stress level:

☐ Low ☐ Average ☐ Above average ☐ High ☐ Very high

How would you describe your diet? Please check all that apply.

- ☐ Vegetarian
- ☐ Red meat (primarily)
- ☐ Poultry/fish (primarily)
- ☐ Fish only
- ☐ Low-fat diabetic
- ☐ Low-salt Mediterranean
- ☐ Check if you eat dairy products
- ☐ Check if you are lactose-intolerant

Personal Safety

Do you:	Always	Sometimes	Never
Wear a helmet when riding a bike?	☐	☐	☐
Have smoke detectors in your home?	☐	☐	☐
Have a carbon monoxide detector?	☐	☐	☐
Wear your seatbelt when riding in a car?	☐	☐	☐
Talk on your cell phone while driving?	☐	☐	☐
Have guns in your home?	☐	☐	☐
If yes, are they locked?	_____		
Have a living will?	☐	☐	☐
If yes, date last updated?	_____		
Have an advanced directive?	☐	☐	☐
If yes, date last updated?	_____		

Family Medical History

Though some questions may seem repetitive, your answers will help our physicians best understand your family medical history.

Any family history of the following?		Maternal	Paternal
Alzheimer's disease		☐	☐
Anxiety/depression		☐	☐
Bleeding disorders		☐	☐
Cancer:	Breast	☐	☐
	Colon	☐	☐
	Melanoma	☐	☐
	Ovarian	☐	☐
	Prostate	☐	☐
	Other	☐	☐
Diabetes		☐	☐
Heart attack		☐	☐
Heart bypass surgery		☐	☐
Angioplasty (stent)		☐	☐
High blood pressure		☐	☐
Kidney disease		☐	☐
Kidney stones		☐	☐
Osteoporosis		☐	☐
Stroke		☐	☐
Other _____		☐	☐

Race or nationality of parents_____

	Living	Present Age or Age at Death	Significant Health Problems or Cause of Death
Father:	☐ Yes ☐ No	_____	_____
Mother:	☐ Yes ☐ No	_____	_____
Spouse/domestic partner:	☐ Yes ☐ No	_____	_____
Maternal grandmother:	☐ Yes ☐ No	_____	_____
Maternal grandfather:	☐ Yes ☐ No	_____	_____
Paternal grandmother:	☐ Yes ☐ No	_____	_____
Paternal grandfather:	☐ Yes ☐ No	_____	_____

Brothers: Number living_____ Number dead_____

Significant health problems _____

_____

Cause(s) of death_____

_____

Sisters: Number living_____ Number dead_____

Significant health problems _____

_____

Cause(s) of death_____

_____

Children: Number living_____ Number dead_____

Significant health problems _____

_____

Cause(s) of death_____

_____