Phone: (503) 741-3570

10 Pier 1, Suite 301

Astoria, OR 97103

Baxter Family Medicine

Direct Primary Care

Fax: (503) 741-3569

www.baxterfamilymedicine.com

Patient Enrollment Form

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suffix: \_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:  Male  Female

Primary E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext:\_\_\_\_\_\_\_\_

Preferred Contact Method:

Cellphone  Text-Message  Home phone  Voicemail  E-mail

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contacts:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

Medications: *please list all medications, supplements and vitamins you are currently taking, include how much and how many you are taking.*

*Example: Tylenol 200mg 2 times a day*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunizations: *please include the year of most recent.*

\_\_\_\_\_\_\_\_ Hepatitis B Series

\_\_\_\_\_\_\_\_ Gardasil

\_\_\_\_\_\_\_\_ PCV13 (prevnar13)

\_\_\_\_\_\_\_\_ Chicken Pox Vaccine or Disease

\_\_\_\_\_\_\_\_ PPSV23

\_\_\_\_\_\_\_\_ Flu

\_\_\_\_\_\_\_\_ Tuberculosis Screening

\_\_\_\_\_\_\_\_ Tetanus

\_\_\_\_\_\_\_\_ Covid-19

Health Maintenance: *please include the year of most recent.*

\_\_\_\_\_\_\_\_ Bone Density Scan

\_\_\_\_\_\_\_\_ Colonoscopy

\_\_\_\_\_\_\_\_ Eye Exam

\_\_\_\_\_\_\_\_ Mammogram

\_\_\_\_\_\_\_\_ Pap smear

\_\_\_\_\_\_\_\_ Physical

Social History:

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking *(Packs per day):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Quit Smoking *(when)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol: *Drinks Per Day:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Drinks Per Week:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine: *Drinks Per Day:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Type:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational Drugs *(Describe)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Diet *(Describe):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Regular Exercise *(Describe)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexually Active *(circle all that apply)* : Males | Females

Gynecologic History:

Age of First Menses: \_\_\_\_\_\_\_\_\_\_

Menopause:  Yes  No

Abnormal Pap smear:  Yes  No

Painful Periods:  Yes  No

Regular Periods:  Yes  No

PMS Symptoms:  Yes  No

Pain with Intercourse:  Yes  No

Content with Sex life:  Yes  No

Obstetric History:

Number of Pregnancies: \_\_\_\_\_\_\_

Number of Full-Term Pregnancies: \_\_\_\_\_\_\_\_

Number of Pre-Term Pregnancies: \_\_\_\_\_\_\_

Miscarriages: ­­\_\_\_\_\_\_\_

Abortions: \_\_\_\_\_\_\_

Tubal: \_\_\_\_\_\_\_\_

Infertility Issues: Yes | No

Health History *(select all that apply)*:

Abnormal EKG

Heart Attack

High Blood Pressure

Stroke

Chest Pain

High Cholesterol

Peripheral Vascular Disease

Asthma

Obstructive Sleep Apnea

Snoring

Emphysema or COPD

Shortness of Breath

Eye Problems

Hearing Loss

Sinus Problems

Acid Reflux

Crohn’s Disease

Irritable Bowel Syndrome

Hernia

Ulcerative Colitis

Constipation

Diarrhea

Gall Bladder Disease

Liver Disease

Urinary Infections

Erectile Dysfunction

Urinary Incontinence

Kidney Disease or Stones

Sexually Transmitted Disease

Osteoarthritis

Gout

Rheumatoid Arthritis

Neck or Spinal Problems

Health History Continued *(select all that apply)*:

Concussion

Migraines

Headache

Epilepsy or Seizures

Anemia

Cancer

Blood Clots

Sickle Cell

Diabetes

Pancreatitis

Thyroid Disease

Acne

Skin Disorders

Psoriasis

Melanoma

ADD or ADHD

Depression

OCD

Anxiety

Memory Loss

Suicidal Thoughts or Attempts

Surgical History *(Year of most recent)*:

\_\_\_\_\_\_\_ Tonsils (Tonsils and Adenoids)

\_\_\_\_\_\_\_ Cholecystectomy (Gall bladder)

\_\_\_\_\_\_\_ Hysterectomy

\_\_\_\_\_\_\_ Joint Replacement

\_\_\_\_\_\_\_ Heart Catheter

\_\_\_\_\_\_\_ Heart Stent

\_\_\_\_\_\_\_Colonoscopy

\_\_\_\_\_\_\_ EDG

\_\_\_\_\_\_\_ Spine Surgery

\_\_\_\_\_\_\_Breast Biopsy

\_\_\_\_\_\_\_ Prostate Surgery

\_\_\_\_\_\_\_ Hernia Repair

\_\_\_\_\_\_\_ Carpal Tunnel Surgery

\_\_\_\_\_\_\_ Cesarean Section

\_\_\_\_\_\_\_ Myringotomy (ear tube)

\_\_\_\_\_\_\_ Vasectomy

\_\_\_\_\_\_\_ Other

Allergies *(Please list Allergy and Reaction)*:

Medications and Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History *(select all that apply)*:

Asthma

Father

Mother

Sibling

Child

Bleeding Disorder

Father

Mother

Sibling

Child

Breast Cancer

Father

Mother

Sibling

Child

Colon Cancer

Father

Mother

Sibling

Child

Depression

Father

Mother

Sibling

Child

Anxiety

Father

Mother

Sibling

Child

Drug Addiction

Father

Mother

Sibling

Child

Alcohol Addiction

Father

Mother

Sibling

Child

Heart Disease

Father

Mother

Sibling

Child

High Blood Pressure

Father

Mother

Sibling

Child

High Cholesterol

Father

Mother

Sibling

Child

Kidney Disease

Father

Mother

Sibling

Child

Leukemia

Father

Mother

Sibling

Child

Liver Disease

Father

Mother

Sibling

Child

Lung Cancer

Father

Mother

Sibling

Child

Osteoporosis

Father

Mother

Sibling

Child

Ovarian Cancer

Father

Mother

Sibling

Child

Pancreatic Cancer

Father

Mother

Sibling

Child

Rheumatoid Arthritis

Father

Mother

Sibling

Child

Stroke

Father

Mother

Sibling

Child

Thyroid Disease

Father

Mother

Sibling

Child

Prostate Cancer

Father

Mother

Sibling

Child

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Father

Mother

Sibling

Child