OAK STREET MEDICAL, P.C.

Date:

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Thank you for allowing us to become partners in your Health Care!

Enclosed you will find paperwork we need you to complete and bring with you for your appointment. If this is not completed when you come in it may delay your appointment time. Please arrive 20 minutes prior to your appointment time as additional paperwork will be needed at check in as part of the new patient registration process.

PRIMARY CARE APPOINTMENTS:

§ If you are establishing care with **any Oak Street Medical Practitioner** for primary care, we may ask that you have your records sent from your previous physicians at the time of your appointment.

§ The Physicians need you to bring your medications, including all over the counter medication and vitamins, in their original bottles.

§ If you are establishing care with **any Oak Street Medical Practitioner** as your primary physician and your insurance plan is managed care (Providence Medicare Align, Providence Medicare Choice, PacificSource Prime, PacifiSource Medicare HMO, or Aetna, etc….) **PLEASE** call your insurance and have your PCP changed prior to your appointment.

§ As a courtesy, our office will contact your insurance company to verify coverage and benefits. Please call us if you have questions about the amount you will need to be prepared to pay at your first appointment. Co-payments, Co-insurance and Deductible amounts are payable at the time of service. We accept cash, checks made payable to Oak Street Medical, Visa, MasterCard and Discover.

§ **Late Appointments:** The office may need to reschedule your appointment if you are late.

§ **Cancellations:** Our office requires 24 hour notice if an appointment cannot be kept. If you are unable to make your scheduled appointment, please notify us as soon as possible.

SPECIALIST APPOINTMENTS:

§ If your insurance is a managed care plan, a referral is required from your primary care physician in order to be seen by a specialist. If you are seeing a specialist at Oak Street Medical, please call to make sure the referral has been requested from your primary physician and received by the specialist if you.

If you have any questions, please feel free to call the office during regular business hours.
We look forward to meeting you soon.

Warmest regards,

The Office Staff
Oak Street Medical

Oak Street Medical – Medical Summary Date:

Patient Name:	Preferred Name:	DOB:	Pt #:

Please List Your Primary Health Concerns:

Medical Problem List:

Medication Reconciliation (Please **bring all** your medications/supplements when you come in)

Name:	Strength:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Pharmacies that you use:

Mark Immunizations you have had (For recommended immunizations www.cdc.gov/vaccines/schedules)

☐ Influenza Date:	☐ Hepatitis B Date:	☐ Hepatitis A Date:
☐ Varicella Date:	☐ Meningococcal Date:	☐ Gardasil (HPV) Date:

☐ Shingles (Zostavax) Date:	☐ Pnevmovax (23)(old Pneumonia shot) Date:
☐ Measles, Mumps, Rubella (MMR) Date:	☐ Prevnar (New Pneumonia Shot) Date:
☐ Tetanus, Diphtheria, Pertussis, TDAP Date:	☐ Have you ever had Chicken pox or exposure to Date:

Health Maintenance – Exams you have had done:

Eye Exam	Date:	☐ Never
Pelvic Exam or Pap Smear (Female only)	Date:	☐ Never
Mammogram (Female only)	Date:	☐ Never

Patient Name:_________________________ DOB:__________

History of HIV Testing	Date:	☐ Never
Colonoscopy	Date:	☐ Never
Stool Testing	Date:	☐ Never
Bone Density	Date:	☐ Never
A1C (Patients with Diabetes)	Date:	☐ Never
PSA (Males only)	Date:	☐ Never
XRays (by other Providers)	Date:	☐ Never
Labs (by other Providers)	Date:	☐ Never
INR/Prothrombin/Coumadin/Afib/blood thinners (*if applicable what is current dose)	Date:	☐ Never
Have you had any hospitalizations, operations, or health events (existing patients since last exam)?		
Do you drink alcohol? ☐ yes ☐ no If yes how much in 1 week:		
MEN: How many times in the past year have you had 5 or more drinks in a day?	☐ None	☐ 1 or more
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	☐ None	☐ 1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	☐ None	☐ 1 or more
What recreational drugs have you used?		

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "x" to indicate your answer)	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	0	1	2	3
Healthcare professional , add Columns:				
For interpretation of TOTAL, please refer to accompanying scoring card.	TOTALS			

Patient Name:_______________________ DOB:__________

Tobacco Use	Ever used ☐YES ☐NO	When:	What type:	Date stopped:
	Current use:	What type:		How much:

What measures have you used to stop?
See (www.smokefreeoregon.com)

Social History:

Marital Status: ☐ Single ☐ Single w/Partner ☐ Married ☐Divorced ☐ Separated ☐ Widowed

Occupation:

Sexual History

Sexually Active ☐ YES ☐ NO Monogamous Relationship ☐ YES ☐ NO

Have you ever had a sexually transmitted disease? ☐ YES ☐ NO Are you worried about having a STD? ☐ YES ☐ NO

Women's Health

Are you having menses? ☐ YES ☐ NO Are menses monthly? ☐ YES ☐ NO Last menstrual period Date:

Painful ☐ YES ☐ NO Any Problems?

Post Menopausal ☐ YES ☐ NO
History of Hormone Replacement Therapy ☐ YES ☐ NO

# of Pregnancies: # of children: Birth Control Method:

Prior hysterectomy: Ovaries Removed?:

Patient Assistive Devices

Eyeglasses: ☐ Reading ☐ Distance ☐ Driving	☐ Hearing Aids	☐ Cane
☐ Walker ☐Wheelchair	☐ Home Oxygen	☐ Incontinence Pads
☐ CPAP ☐ Other:		

Do you have trouble with: ☐ Hearing ☐ Eyesight ☐ Memory ☐ Ambulation ☐ Balance ☐ Incontinence

Have you had any Falls recently?

Family History

Relation	Age	Medical Illnesses	Age at Death	Cause of Death	Any Family history of :
Father					☐ Diabetes
Mother					☐ Hypertension
Brother/Sister					☐ Coronary Disease
Brother/Sister					☐Cancer
Brother/Sister					☐Stroke
Brother/Sister					☐ Other Diseases:
Spouse					
Child					
Child					
Child					
Child					

Patient Name:___________________________ DOB:___________

Diet and Weight

Are you on a special diet? ☐ YES ☐ NO Do you have dietary concerns? ☐ YES ☐ NO

Has your weight changed? ☐ YES ☐ NO Amount?

General Health

In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

How much pain have you had during past 4 weeks? ☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Activities of Daily Living

Following tasks are you:	Independent: can do by myself	Require Assistance: need help from another	Dependent: cannot do at all		Independent: can do by myself	Require Assistance: need help from another	Dependent: cannot do at all
Walking	☐	☐	☐	Using Telephone	☐	☐	☐
Dressing	☐	☐	☐	Shopping	☐	☐	☐
Bathing	☐	☐	☐	Preparing Meals	☐	☐	☐
Eating	☐	☐	☐	Housework	☐	☐	☐
Toileting	☐	☐	☐	Taking Medication	☐	☐	☐
Driving	☐	☐	☐	Managing Finance	☐	☐	☐

End of Life Planning:

Do you have an advanced directive or living will? ☐ YES ☐ NO

If not, are you interested in discussing at your next appointment? ☐ YES ☐ NO

Other Medical Providers. These are the current specialists co-involved in my care:

Specialty/Reason	**Name**	**If new Patient list any medical problems:**
Ophthalmologist		
Cardiologist		
Pulmonologist		
Gastroenterologist		
Oncologist		
Dermatologist		
Orthopedist		
Urologist		
Gynecologist		
Allergist		
Dental		
Therapist		
Psychologist/Psychiatrist		
Other		

Have you recently traveled outside of the U.S.? ☐ Yes ☐ No Do you plan on traveling outside of the U.S.? ☐ Yes ☐ No