TUALITY HEALTHCARE
An OHSU Partner

Patient history form

Name: _____ Date: _____

Height: _____ Weight: _____

History of present illness

Reason(s) for this visit: _____

Duration of above complaint (*please indicate number*): _____ week's _____ month's _____ years

Have you been treated for this condition in the past? ❒ No ❒ Yes If yes, please explain: _____

_____

_____

Frequency of urination: daytime _____ nighttime _____

Strength of stream: ❒ normal ❒ decreased ❒ poor

Are you experiencing any of the following symptoms *(please circle Yes or No)*?

Blood in urine	Y N _____	Leakage of urine	Y N _____
Urinary infections	Y N _____	Interruption of stream	Y N _____
Kidney or bladder stone	Y N _____	Split stream	Y N _____
Burning or pain with urination	Y N _____	Dribbling after urination	Y N _____
Difficulty starting urination	Y N _____	Urgent urination	Y N _____

Have you had any x-rays related to this condition? Y N If yes, when and where were these performed?

_____

Past medical history

Have you ever had any of the following (*please circle Yes or No*)?

Heart disease	Y N _____	Cancer	Y N _____
High blood pressure	Y N _____	Blood transfusion	Y N _____
Lung disease (COPD)	Y N _____	Kidney problems	Y N _____
Diabetes	Y N _____	Gastrointestinal disease	Y N _____
Glaucoma	Y N _____	Bleeding problems	Y N _____
Hepatitis	Y N _____	Artificial Joint	Y N _____

Other illness not listed: _____

Past surgical history

Please list all of the operations that you have had:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

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Social history

Do you or have you used tobacco? ❒ No ❒ Yes How many packs per day: _____ how long: _____ year quit: _____

Do you drink alcohol? ❒ No ❒ Yes How much: _____ how long: _____ year quit: _____

How many glasses do you drink daily: Coffee _____ Water _____ Tea _____ Soda _____ Juice _____

Medications (*please include aspirin and vitamins*):

	Name	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Allergies (*please list medications and type of reaction*):

1. _____ 3. _____
2. _____ 4. _____

Do you have a family history of the following?

Father Mother Brother Sister Son Daughter Other: _____

Bleeding disorder _____ Kidney disease _____

Diabetes _____ Kidney stone _____

Gastrointestinal complication _____ Prostate cancer _____

Heart disease _____ UTI (urinary tract infection) _____

For women only

1. How often do you leak urine (*please circle the degree*)? _____

   0 1 2 3 4 5
   Never All the time

2. How much urine do you usually leak?

   0 1 2 3 4 5
   None Large amount

3. Overall, how much does leaking interfere with your lifestyle?

   0 1 2 3 4 5 6 7 8 9 10
   Not at all A great deal

4. When do you leak urine?

   - ❒ Never
   - ❒ For no obvious reason
   - ❒ While sleeping
   - ❒ Before reaching toilet
   - ❒ Washing hands
   - ❒ All the time
   - ❒ Cough/sneeze
   - ❒ Lifting or exercise
   - ❒ When standing
   - ❒ Unlocking front door

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Review of systems

Please circle YES (Y) or NO (N). Please explain any YES answers in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Night sweats	Y	N
Weight Loss/ anorexia	Y	N
Headache	Y	N

Other: _____

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

Other: _____

Allergic/ Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Other: _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N

Other: _____

Endocrine

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other: _____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other: _____

Cardiovascular

Chest pain	Y	N
Varicose Veins	Y	N
High blood pressure	Y	N

Other: _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other: _____

Musculoskeletal

Joint pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Other: _____

Ear/ Nose/ Throat/ Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Other: _____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other: _____

Respiratory

Wheezing	Y	N
Persistent cough	Y	N
Shortness of breath	Y	N
Bloody sputum	Y	N

Other: _____

Hematological/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other: _____

Psychological

Are you generally satisfied with life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other: _____

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Authorization to communicate protected health information

In general, the HIPAA privacy policy rule gives the individuals the right to request restrictions on uses and disclosures of health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means.

I wish to be contacted in the following manner (check all that applies):

- ❑ Home telephone: _____
  - ❒ Okay to leave message with detailed information
  - ❒ Leave message with call back number only
- ❑ Other telephone: _____
  - ❒ Okay to leave message with detailed information
  - ❒ Leave message with call back number only
- ❑ Written communication
  - ❒ Okay to mail to my home address
- ❑ Okay to discuss personal health information with:

  _____

  _____

  _____

This authorization will be ongoing, but can be amended or revoked at any time by signing a new authorization form.

_____ _____

Patient signature Date

_____ _____

Print Name Date of Birth

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Tuality Healthcare & Tuality/OHSU Cancer Center Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received a copy of the Tuality Healthcare & Tuality OHSU Cancer Center ("Tuality") Joint Notice of Privacy Practices.

I understand that Tuality may use or disclose my health information to carry out treatment, payment, or healthcare operations. Health information means any and all information relating to healthcare services provided to me by Tuality, including information related to services provided to me prior to the date I sign this form.

I understand that the Joint Notice of Privacy Practices explains the types of uses or disclosures that can be made, and also explains my rights with respect to my health information.

I understand that if I have questions or concerns about my rights or the privacy practices of Tuality, I may contact the Privacy Officer at the address listed below.

I understand that Tuality may change the terms of the notice from time to time, and that I may view the current notice on the Tuality Healthcare website at www.tuality.org or request a copy from most Tuality registration desks.

Tuality Healthcare
Privacy Officer
335 SE 8th Ave.
Hillsboro, OR 97123

_____ _____
Signature Date

❒ Unable to sign, reason: _____

_____

❒ Unwilling to sign, reason: _____

_____

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