Zócalo Wellness
2100 NE Broadway #225, Portland, OR, 97232
(503) 719-5000

Patient Questionnaire

Preferred Name _____Pronoun(s):_____

Legal Name _____ Today's Date _____
Last First M.I.

Date of Birth _____ Age _____ Gender _____Sex _____

Home Address _____

_____

Occupation/Employer Name _____

Home Phone Number _____ Cell Phone Number _____

May we leave a message identifying ourselves at these numbers? ❑ Yes ❑ No

Email _____

How would you like to be reached? ❑ Home ❑ Cell ❑ Email ❑ Text

PLEASE NOTE: Email and text are not secure forms of communication but can be used for your convenience to convey information regarding your appointments.

Would you like to receive our newsletter? ❑ Yes ❑ No

Emergency Contact _____

Relationship to Patient _____ Phone _____

How did you hear about us? _____

Please list health care providers you regularly see (including mental health and primary care):

Provider Full Name	**Name and Type of Practice**

What are your most important health concerns?

1. (Most Important) _____
2. _____
3. _____
4. (Least Important) _____

Please check any conditions you have or have had in the past:

- ❑ HIV+
  Date diagnosed:_____
- ❑ Hepatitis B/Hepatitis C
- ❑ Cancer
- ❑ Diabetes
- ❑ Genetic
  Disorder:_____
- ❑ Anxiety
- ❑ Depression
- ❑ Difficulty in focusing
- ❑ Dizziness
- ❑ Easily startled
- ❑ Excessive worry
- ❑ Excessive anger
- ❑ Excessive fear
- ❑ Fatigue/tiredness
- ❑ Headaches
- ❑ Loss of sleep/poor sleep
- ❑ Loss or gain of weight
- ❑ Nervousness/irritability
- ❑ Overwhelmed by life
- ❑Addiction

SKIN

- ❑ Boils
- ❑ Bruise easily
- ❑ Dry skin
- ❑ Itching/rash
- ❑ Sensitive skin
- ❑ Sores won't heal
- ❑ Sweats

MUSCLE/JOINT/ BONES

- ❑ Tremors or Cramps
- ❑ Swollen joints
- ❑ Pain
- ❑ Weakness
- ❑ Numbness
- ❑ Arthritis

GENITO/URINARY

- ❑ Blood/pus in urine
- ❑ Frequent urination
- ❑ Inability to control urine
- ❑ Kidney infection/stones
- ❑ Lowered libido

CARDIOVASCULAR/ BLOOD

- ❑ Chest pain
- ❑ Hardening of arteries
- ❑ Elevated cholesterol/lipids
- ❑ High or Low blood pressure
- ❑ Pain over heart
- ❑ Poor circulation
- ❑ Previous heart attack
- ❑ Rapid/irregular heart beat
- ❑ Swelling of ankles
- ❑ Anemia
- ❑ Bleeding disorders
- ❑ Blood clots

REPRODUCTIVE

- ❑ Erectile difficulty
- ❑ Premature ejaculation
- ❑ Hernia
- ❑ Prostate disease
- ❑ Inability to conceive
- ❑ Bleeding between periods
- ❑ Clots in menses
- ❑ Excessive menstrual flow
- ❑ Extreme menstrual pain
- ❑ Irregular cycle
- ❑ Menopausal symptoms
- ❑ PMS
- ❑ Previous miscarriage
- ❑ Scanty menstrual flow
- ❑ Breast lump

EYES/EARS/NOSE/ THROAT/ RESPIRATORY

- ❑ Asthma/wheezing
- ❑ Blurred or failing vision
- ❑ Difficulty breathing
- ❑ Earache
- ❑ Enlarged glands
- ❑ Eye pain
- ❑ Frequent colds
- ❑ Hay fever/environmental allergies
- ❑ Gum trouble
- ❑ Nose bleeds
- ❑ Loss of hearing
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Allergies

GASTROINTESTINAL

- ❑ Belching, gas or bloating
- ❑ Food sensitivities
- ❑ Diverticulosis/Diverticulitis
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty swallowing
- ❑ Distention of abdomen
- ❑ Excessive hunger
- ❑ Gall bladder trouble
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Pain over stomach
- ❑ Poor appetite
- ❑ Vomiting

Could you be pregnant? ❑ Yes ❑ No

How long has it been since you had a complete medical exam?_____

Current Medications: Please list all prescription medications, over-the-counter medications, vitamins, herbs and nutritional supplements you use. Attach additional pages if necessary.

Substance	Dose and Frequency	Start date	Reason for Taking

Please list any hospitalizations or surgeries with dates: _____

_____

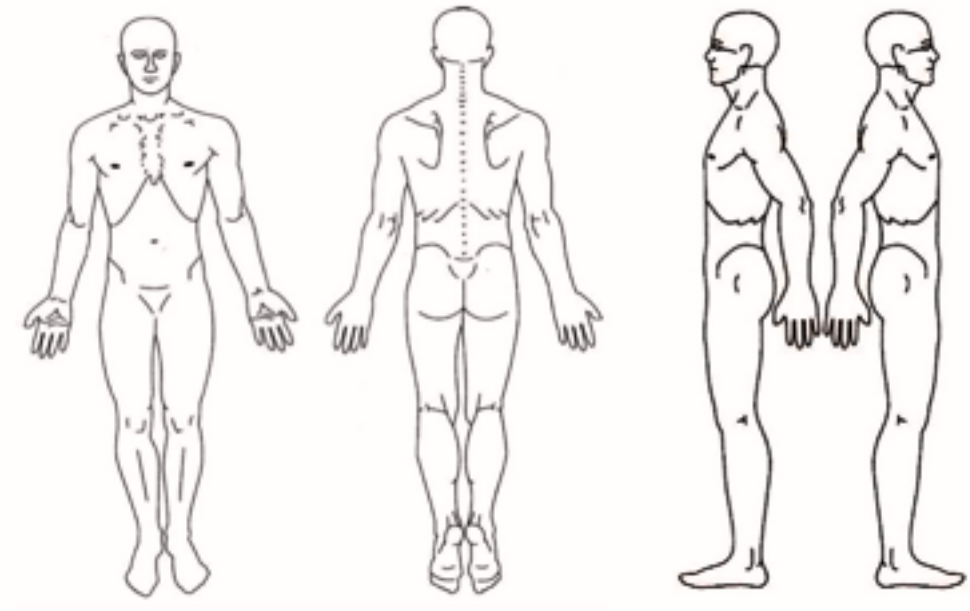
Check conditions that have occurred in blood relatives:

❑ Diabetes ❑ Obesity ❑ High Cholesterol ❑ Stroke ❑ High Blood Pressure

❑Cancer, kind:_____ ❑ Heart Disease ❑ Mental Illness ❑ Kidney Disease

❑Other relevant family history: _____

Please circle below areas where you have:
Pain, Burning, Numbness, Tingling, Cramping, Weakness



Signature of Patient or Representative: _____

Printed Name: _____Date: _____