CORVALLIS FAMILY MEDICINE, P.C.
Established Patient Teen / Adult Intake Questionnaire

Name:_____ Date:_____

DOB:_____ Sex: Male / Female / Transgender / Other:_____

Family History

If no changes in the last year, please check here and skip to Preventative Screenings ☐

Note any changes here

(check all that apply)

Relative	Are they alive?	Current Age (or at death)	Diabetes	High blood pressure	Heart disease	Stroke	Psychologic	Breast cancer	Prostate cancer	Colon cancer	Other (please specify)
Father	Y / N										
Mother	Y / N										
Brother(s)	Y / N										
Sister(s)	Y / N										
Son(s)	Y / N										
Daughter(s)	Y / N										
Paternal Grandfather	Y / N										
Paternal Grandmother	Y / N										
Maternal Grandfather	Y / N										

Preventative screenings	Month/Year (approx.)
Last physical exam	
Last screening lab work	
Colonoscopy	
Bone density (DEXA)	
STD screen	
PSA/Prostate (males only)	

In the last 2 weeks, have you…		
Had little interest or pleasure in doing things?		
	Yes	No
Felt down, depressed or hopeless?		
	Yes	No

Females only	
Mammogram	
Pap smear	
Start of last menstrual period	
Age of menopause	

Total pregnancies	
Term birth (>37w)	
Premature birth (20-37w)	
Miscarriage or abortion (<20w)	
Living (current)	

Social History

Tobacco	Do you currently smoke or chew?	Yes	No	I have quit
If quit	How many years ago?			
If quit or current	How many years of use?			
If quit or current	How many packs per day? (average)			
If current	Are you interested in quitting?	Yes	No	Thinking about it
Alcohol	Have you had a drink in the last year?	Yes	No (if no, skip to drug use)	

How often do you have alcohol?	Never	Once per month or less	2-4 times per month	2-3 times per week	4+ times per week
How many drinks per occasion (average)	1-2	3-4	5-6	7-9	10+
How often do you drink more than 6 (female) or 8 (male)?	Never	Less than once per month	Monthly	Weekly	Daily

Drug use	Never	Past Use	Current Use	Drugs of choice:
Marijuana use	No	Occasional	Daily or almost daily	
Marital status	Single	Married	Domestic partner	Divorced / Widowed
Orientation	Straight	Homosexual	Bisexual	Other:
Are you sexually active?	Yes	No		
What is your job?				
What is your level of education?				
Exercise	How often?	Types:		
Caffeine	How much per day?	Types:		

Any health changes or surgical procedures since your last physical / yearly visit?	Yes	No
If yes, please list:		
What goals do you have for your health?		