WASHINGTON HEALTH SYSTEM
Primary Care - Lakeside

In order for us to get to know you and your health care needs, please fill out the following form to the best of your ability. Our goal is to provide you with exceptional health care, and it starts with getting to know you.

**NAME:_____DATE OF BIRTH:_____AGE:_____**

**Please let us know how you heard about our practice. Check all the ways that we have caught your attention.**

**Billboards_____** **Website_____** **Radio Commercial_____**

**Magazine ads_____** **Google search_____** **Insurance Company_____**

**Mailing _____** **Personal referral_____** **Previous patient of the physician_____**

**Other - Please tell us where…**

**_____**

***Our organization takes care of people with different needs and we make every attempt to make all feel comfortable and welcome. During the registration process you will be asked questions about information that may impact your health care, including Race, Ethnicity, Sex and Sex at Birth.***

**Please circle the best response:**

Race Information (Please circle): White Black/African American Asian Alaskan or Native American Hawaiian or Pacific Islander Hispanic/Latino More than one race I prefer not to disclose

What was the gender on your birth certificate? Please circle: Male Female Unknown

| **Sexual orientation (PLEASE CHECK):** | | **Gender identity (PLEASE CHECK):** | |
|---|---|---|---|
| Lesbian, Gay, or Homosexual | | Male | |
| Straight or Heterosexual | | Female | |
| Bisexual | | Female to Male/Transgender Male | |
| Do Not Know | | Male to Female/Transgender Female | |
| Choose Not to Disclose | | Genderqueer; neither exclusively male | |
| Something else; describe | | Choose not to disclose | |
| | | Other category; | |

**OCCUPATION**:_____**MARITAL STATUS**: S M D W OTHER_____

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**WHO RESIDES WITH YOU IN YOUR HOME** (PLEASE INCLUDE - NAME, AGE, AND RELATIONSHIP TO YOU)

| | |
|---|---|
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**MEDICAL HEALTH HISTORY**

**WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?** (PLEASE INCLUDE NAME AND DOSAGE)

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|---|---|---|
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**PLEASE CHECK BOX TO THE RIGHT IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:**

| | | | | | |
|---|---|---|---|---|---|
| ALCOHOL ABUSE | | GLAUCOMA | | OSTEOPOPENIA | |
| ALLERGIES | | GOUT | | OSTEOPOROSIS | |
| ASTHMA | | GERD (REFLUX) | | PALPITATIONS | |
| ANEMIA | | HEADACHES | | PSORIASIS | |
| ANXIETY | | HEART DISEASE | | PROSTATE | |
| ARTHRITIS | | HEART MURMUR | | PROSTATITIS | |
| BACK PAIN | | HEMORROIDS | | RHEUMATIC FEVER | |
| COPD | | HEPATITIS | | SCIATICA | |
| CANCER | | HIGH BLOOD PRESSURE | | SEXUAL | |
| CONSTIPATION | | HIGH CHOLESTEROL | | STOMACH ULCERS | |
| CROHN'S DISEASE | | HYPERTHYROIDISM | | STROKE (CVA) | |
| DEPRESSION | | HYPOTHYROIDISM | | SWOLLEN ANKLES | |
| DIABETES TYPE I | | INSOMNIA | | SEIZURES | |
| DIABETES TYPE II | | IRRITABLE BOWEL | | STD | |
| DIVERTICULITIS | | KIDNEY STONES | | TUBERCULOSIS | |
| DRUG ABUSE | | KIDNEY DISEASE (RENAL | | RECURRENT UTI'S | |
| FIBROMYALGIA | | LIVER DISEASE | | ULCERATIVE COLITIS | |
| GALL BLADDER | | MELANOMA | | OTHER: | |

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**ARE YOU ALLERGIC TO ANYTHING?**
(PLEASE LIST ALL ALLERGIES-MEDICATIONS, DYES, ENVIRNOMENTAL, TAPE, ETC… AND THE REACTION IT CAUSES)

| | |
|---|---|
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**PLEASE LIST ANY PRIOR SURGERIES** (INCLUDE DATE IF KNOWN):

| **TYPE OF SURGERY** | **DATE** |
|---|---|
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**FAMILY HISTORY:**

**PLEASE COMPLETE TABLE INDICATING MEDICAL HISTORY OR FAMILY MEMBERS TO THE BEST OF YOUR KNOWLEDGE**:

| | Alive Y/N | AGE | DIABETES | HEART DISEASE | CANCER | MENTAL ILLNESS (ANXIETY, DEPRESSION ETC) | DRUG & ALCOHOL ADDICTION | BLOOD CLOTS | BLEEDING DISORDER | HIGH BLOOD PRESSURE | OTHER PLEASE LIST |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **FATHER** | | | | | | | | | | | |
| **MOTHER** | | | | | | | | | | | |
| **SISTER** | | | | | | | | | | | |
| **BROTHER** | | | | | | | | | | | |
| **SON** | | | | | | | | | | | |
| **DAUGHTER** | | | | | | | | | | | |
| **PATERNAL GRANDFATHER** | | | | | | | | | | | |
| **PATERNAL GRANDMOTHER** | | | | | | | | | | | |
| **MATERNAL GRANDFATHER** | | | | | | | | | | | |
| **MATERNAL GRANDMOTHER** | | | | | | | | | | | |
| **AUNT/UNCLE** | | | | | | | | | | | |
| **OTHER** | | | | | | | | | | | |

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**PLEASE ANSWER THE FOLLOWING:**

| | | | |
|---|---|---|---|
| **DO YOU SMOKE?** | **NO** | **YES** | **IF YES-EVERY DAY? SOME DAYS? HOW MUCH PER DAY?** |
| **FORMER SMOKER?** | **NO** | **YES** | **IF YES, WHEN DID YOU QUIT?** |
| **CHEWING TOBACCO?** | **NO** | **YES** | **IF YES, EVERY DAY? SOME DAYS? HOW MUCH PER DAY?** |
| **NON-TOBACCO NICOTINE CONTAINING PRODUCTS?** | **NO** | **YES** | **IF YES, WHICH PRODUCT? HOW MUCH PER DAY?** |
| **DO YOU DRINK CAFFEINATED BEVERAGES?** | **NO** | **YES** | **IF YES-HOW MANY CUPS PER DAY?** |
| **DO YOU DRINK ALCOHOL?** | **NO** | **YES** | **IF YES-HOW MUCH PER WEEK?** |
| **DO YOU USE ILLEGAL DRUGS?** | **NO** | **YES** | **IF YES- WHAT KIND AND HOW OFTEN?** |
| **ARE YOU AT RISK FOR HIV?** | **NO** | **YES** | **IF YES-WHY?** |
| **ARE YOU IN AN ABUSIVE RELATIONSHIP?** | **NO** | **YES** | **IF YES- IS IT VERBAL OR PHYSICAL?** |
| **DO YOU EXERCISE?** | **NO** | **YES** | **IF YES-WHAT TYPE?** |
| **DO YOU WATCH YOUR DIET?** | **NO** | **YES** | **IF YES-FOR FAT/CHOLESTEROL/SALT/OTHER?** |

**HAVE YOU HAD ANY OF THE FOLLOWING IMMUNIZATIONS?**

| | | | | |
|---|---|---|---|---|
| **INFLUENZA (FLU)** | **NO** | **YES** | **UNSURE** | **DATE:** |
| **PNEUMONIA** | **NO** | **YES** | **UNSURE** | **DATE:** |
| **TETANUS** | **NO** | **YES** | **UNSURE** | **DATE:** |
| **HEPATITIS B** | **NO** | **YES** | **UNSURE** | **DATE:** |
| **HPV (GARDASIL)** | **NO** | **YES** | **UNSURE** | **DATE:** |
| **SHINGRIX** | **NO** | **YES** | **UNSURE** | **DATE:** |
| **COVID** | **NO** | **YES** | **Manufacturer:** | **DATES:** |

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**PLEASE SHARE WITH US ANY OTHER PHYSICIANS THAT YOU SEE ON A REGULAR BASIS (NAME AND SPECIALITY):**

| | |
|---|---|
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**FEMALE PATIENTS PLEASE COMPLETE THE FOLLOWING:**

WHEN WAS YOUR LAST:

PAP SMEAR:_____

MAMOGRAM:_____

BREAST EXAM:_____

BONE DENSITY TEST:_____

COLONOSCOPY:_____

FIT TEST/COLOGUARD:_____

AGE MENSTRUAL CYCLE BEGAN:_____ FREQUENCY:_____

LENGTH OF PERIODS:_____ LAST MENSTRUAL PERIOD:_____

PREGNANCIES:_____ BIRTHS:_____ MISCARRIAGES:_____

DO YOU USE BIRTH CONTROL?:_____ WHAT METHOD?:_____

ARE YOU CURRENTLY BREAST FEEDING?_____HISTORY OF BREAST FEEDING:_____

**DO YOU HAVE A HISTORY OF:**

| | | |
|---|---|---|
| PROLONGED OR ABNORMAL BLEEDING | NO | YES-PLEASE EXPLAIN |
| LEAKAGE OF URINE | NO | YES-PLEASE EXPLAIN |
| PELVIC PAIN | NO | YES-PLEASE EXPLAIN |
| ABNORMAL DISCHARGE | NO | YES-PLEASE EXPLAIN |

**MALE PATIENTS PLEASE COMPLETE THE FOLLOWING:**

WHEN WAS YOUR LAST:

COLONOSCOPY:_____

FIT TEST/COLOGUARD:_____

*Thank-you for completing all of the requested information. We look forward to getting to know you and taking care of you in an environment that is designed with your health care needs in mind.*