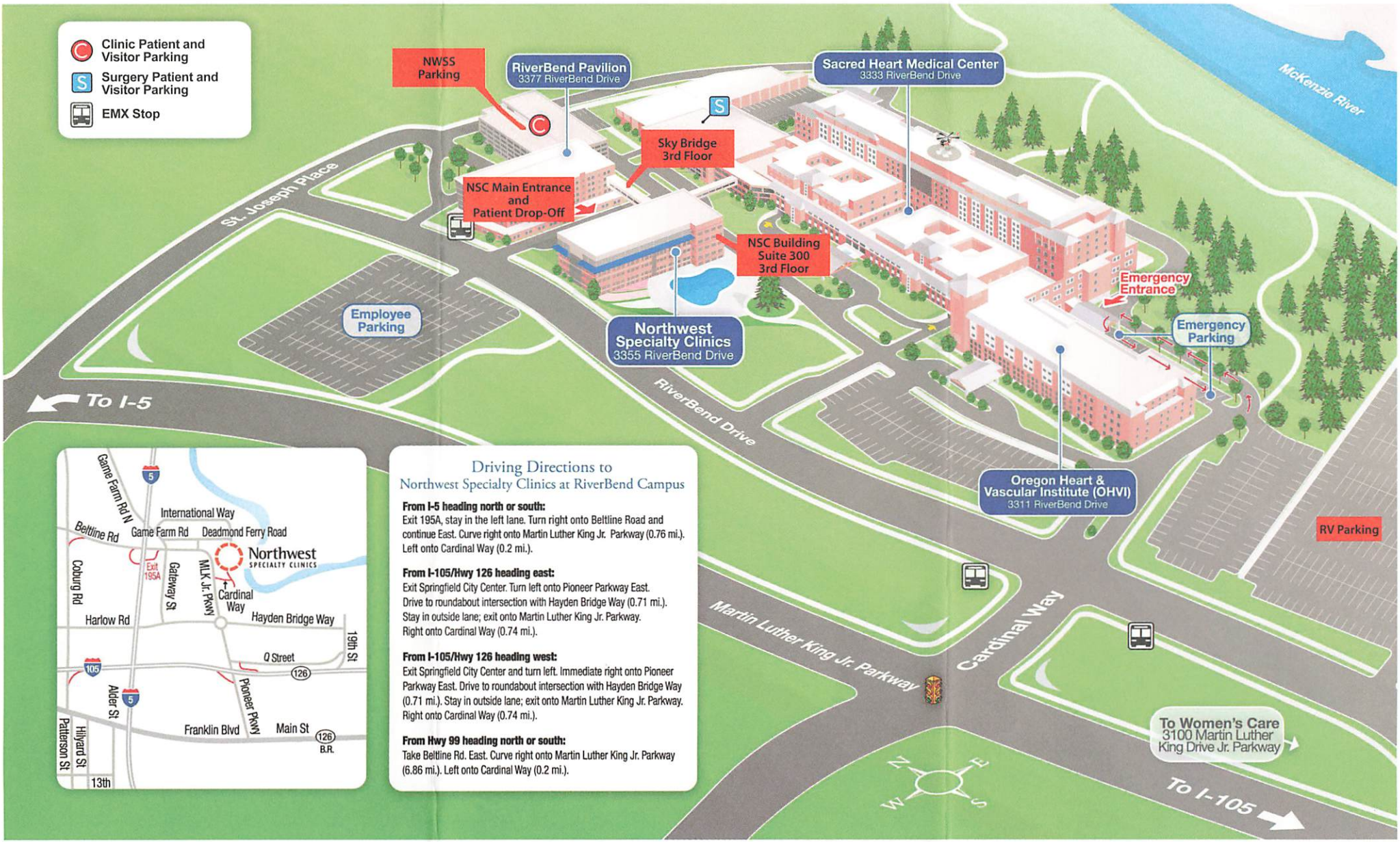
NORTHWEST SURGICAL SPECIALISTS LLP

3355 Riverbend Drive
Suite 300
Springfield, OR 97477
(541) 868-9303 Phone
(877) 687-1336 Toll Free

Finding Your Way

Northwest Surgical Specialists (NWSS) patients and visitors may park in the parking structure Ⓒ on the north side of RiverBend Pavilion. On 3rd floor of parking structure proceed to NSC building via sky bridge. Patient drop-off is located at the NSC main entrance on the ground floor.

Northwest SPECIALTY CLINICS



Driving Directions to Northwest Specialty Clinics at RiverBend Campus

From I-5 heading north or south:
Exit 195A, stay in the left lane. Turn right onto Beltline Road and continue East. Curve right onto Martin Luther King Jr. Parkway (0.76 mi.). Left onto Cardinal Way (0.2 mi.).

From I-105/Hwy 126 heading east:
Exit Springfield City Center. Turn left onto Pioneer Parkway East. Drive to roundabout intersection with Hayden Bridge Way (0.71 mi.). Stay in outside lane; exit onto Martin Luther King Jr. Parkway. Right onto Cardinal Way (0.74 mi.).

From I-105/Hwy 126 heading west:
Exit Springfield City Center and turn left. Immediate right onto Pioneer Parkway East. Drive to roundabout intersection with Hayden Bridge Way (0.71 mi.). Stay in outside lane; exit onto Martin Luther King Jr. Parkway. Right onto Cardinal Way (0.74 mi.).

From Hwy 99 heading north or south:
Take Beltline Rd. East. Curve right onto Martin Luther King Jr. Parkway (6.86 mi.). Left onto Cardinal Way (0.2 mi.).

Northwest Surgical Specialists, LLP
Adult Medical History Form

Full Name: _____ **Date of Birth:** _____

Reason for seeking medical care today, (include symptoms and how long): _____
_____

Your Primary Care Provider: _____
Other Providers involved with your care: _____
Email (Not work-related): _____

***Demographics:** **(Please circle a response below)**

Race: *American Indian or Alaskan Native* *Asian* *Black or African American* *White* *Unknown* *Declined*
Ethnicity: *Not Hispanic or Latino origin* *Hispanic or Latino* *Declined*
Preferred Language: *Chinese* *English* *French* *Russian* *Spanish* *Somali* *Vietnamese* *Sign Language* *Declined*
Need interpreter: *Yes* *No*
Your preferred method of Contact: *Home phone* *Cell phone* *Letter* *Secure Email*

***Health Maintenance:**

Last Mammogram: (month/year): _____
Last Colonoscopy: (month/year): _____
Are you older than 65: *Yes* *No* **If yes, have you had a pneumovax vaccine:** *Yes* *No*

***Review of Symptoms:** (Circle all that apply)

GENERAL: *Fever* *Chills* *Night Sweats*
EYES: *Double Vision* *Loss of Vision*
EARS/NOSE/THROAT: *Swallowing difficulty* *Masses or lumps in your neck*
ENDOCRINE: *Unusually thirsty* *Unusually Hungry* *Chronically fatigued/tired* *Unusual weight loss* *Unusual weight gain*
NEUROLOGICAL: *Episodes of numbness and tingling of arms and legs* *Loss of balance* *Seizures* *Memory problems*
CARDIOVASCULAR: *Chest pain* *Sense of rapid or irregular heartbeat* *Foot or leg swelling* *Racing heart rate* *Calf/leg pain when walking* *Wound/Ulcers on foot or leg*
RESPIRATORY: *Difficulty breathing during activities* *Unable to lie flat or sleep* *Loud snoring or episodes of stopping breathing while asleep* *Chronic cough (day or night)*
GASTROINTESTINAL: *Difficulty swallowing* *Heartburn* *Recent change in bowel habits* *Abdominal pain* *Nausea/Vomiting* *Yellowish skin color* *Loss of bowel control* *Bleeding from your rectum*
GENITOURINARY: *Urinary tract infection* *Painful urination* *Loss of urine control*
MUSCULOSKELETAL: *Leg weakness* *Muscle pains* *Trouble walking*
PSYCHIATRIC: *Anxiety* *Depression* *Phobias/Unusual fears* *Memory problems*

(Circle if this applies): *None of the above*
Please list any problems not covered elsewhere: _____
_____
_____

***Risk Factors** (Circle all that apply)

Tobacco Use:

Current everyday smoker *Current some days/occasional smoker* *Former smoker* *Never smoked*
If you smoke, please circle the amount: *less than ½ pack/day* *1 pack/day* *more than 1 pack/day*

Alcohol Use: *Yes* *No* *#drinks/week*_____
Caffeine Use: *Yes* *No* *#cups/week*_____
HIV/High Risk Behaviors: ***Do you currently have sex with:***
a) 1 sexual partner (monogamous) b) more than1 sexual partner c) Sex with a prostitute d) Unprotected sex e) Shared needle use f) None
Illicit Drug Use: *Yes* *No*

Reviewed by: _____
(Provider Signature)

Northwest Surgical Specialists, LLP

Adult Medical History Form

***Past Medical History** (Circle all that apply):

HX of Cancer:	Abdominal Aortic	Disease	Liver Disease	Circle Below if you have no significant past medical history:
Bladder Cancer	Aneurysm	Crohn's Disease	Lung/Respiratory	
Brain Cancer	Alcoholism	Deafness	Disease	
Breast Cancer	Anemia	Dementia	Lupus	
Cervical Cancer	Anesthetic Complication	Depression	Mental Illness	**No Significant Past Medical History**
Colon Cancer	Angina	Diabetes Type I	Multiple Sclerosis	
Esophageal Cancer	Arrhythmia	Diabetes Type II	Myocardial Infarction	
Head/Neck Cancer	Anxiety	Dialysis	Osteoporosis	
Kidney Cancer	Arthritis	Diverticulosis	Pancreatitis	
Leukemia	Asthma	Diverticulitis	Peptic Ulcer	
Liver Cancer	Atrial Fibrillation	DVT (Blood Clots)	Peripheral Vascular	
Lung Cancer	Autoimmune Problems	Fibromyalgia	Disease	Other:
Ovarian Cancer	Bleeding Disorder	GERD	Pulmonary Embolism	_____
Pancreatic Cancer	Blindness	Gout	Rectocele	_____
Prostate Cancer	Blood Clotting Disorder	Headaches	Renal Artery Stenosis	_____
Rectal Cancer	Breast Disease	Heart Disease	STD	_____
Skin Cancer	Breast Lumps	Hypertension	Stroke	_____
Stomach Cancer	Chest Pain	Hyperlipidemia	Suicide Attempt	_____
Uterine Cancer	Cirrhosis	HIV/AIDS	Thyroid Disease	_____
	Congestive Heart Failure	Kidney Disease	TIA	_____
	Coronary Artery	Kidney Stones	Ulcerative Colitis	

***Past Surgical History** (Circle all that apply):

Breast Surgery:	**Abdominal Surgery:**	**Vascular Surgery:**	**Bariatric Surgery:**
Breast Biopsy: *Right Left*	Appendectomy	Carotid Artery Surgery	Gastric Bypass
Lumpectomy: *Right Left*	Gallbladder removal	Aortic Aneurysm Surgery	Lap Band Surgery
Simple Mastectomy:	Colon Surgery	LUE AV Fistula	
Right Left	Small Bowel Surgery	RUE AV Fistula	**URO/GYNE:**
Mod. Rad. Mastectomy:	W Ileal Pouch	LUE AV Graft	Hysterectomy
Right Left	J Ileal Pouch	RUE AV Graft	Urology Surgery
Sentinel Lymph Node	Colostomy	LLE AV Graft	Gynecology Surgery
Removal: *Right Left*	Ileostomy	RLE AV Graft	Urinary Incontinence Surgery
	Esophageal Hernia Surgery	Vein Surgery	Pelvic Prolapse repair
Axillary Lymph Node	GERD Surgery	Laser Vein Surgery	Prostate Surgery
Removal: *Right Left*	Esophagus Removal	L Leg Bypass	_____
	Pancreatic Surgery	R Leg Bypass	
Endocrine Surgery:	Rectopexy	Aorto-BiFem Bypass	Circle below if you have not had any previous surgeries:
Thyroidectomy-total	Incontinence Surgery	Amputation	
Thyroidectomy-partial			**No Previous Surgery**
Parathyroidectomy-total	**Kidney Surgery:**	**Hernia Surgery:**	_____
Parathyroidectomy-partial	Nephrectomy	Inguinal hernia repair:	
Adrenalectomy	Renal Transplant Surgery	(circle)	OTHER:
Splenectomy	PD Catheter Surgery	*Right Left*	_____
		Open or Laparoscopic	_____
Lung Surgery:	**Rectal Surgery:**	Umbilical Hernia repair:	_____
Lung Removal: *Right Left*	Hemorrhoid Banded	Ventral Hernia repair:	_____
Lung Lobe Removal:	Hemorrhoidectomy		_____
Right Left	Fissurectomy		
	Sphincterotomy	**Orthopedic Surgery:**	
Heart Surgery:	Pilonidal Abscess I&D	(Explain)	
Coronary Artery Bypass Graft	Pilonidal Surgery	Joint Replacement:	
Coronary Stent		_____	
Pacemaker		_____	
		Spine Surgery: _____	

Full Name:_____ **Date:**_____

Reviewed by: _____

(Provider Signature)

Northwest Surgical Specialists, LLP
Adult Medical History Form

***Prescription Medication List:** (If no prescriptions, circle none): **NONE**

Prescribed Medication:	Dosage:	Times per day taken/ Frequency
Example: Prilosec	*Example: 20 mg*	*Example: 3 x day*

***Over-The-Counter (OTC) Medication** (If no OTC medication, please circle none): **NONE**

OTC Medication:	Dosage	Frequency
Example: Vit D 3	*Example: 5000mg*	*Example: Daily*

***Allergy History:** (If no allergies, circle none): **NONE**

Medication Allergy:	Type of Reaction	Severity of Reaction (please circle one)
Example: Sulfa	*Example: Hives, Rash, Anaphylaxis*	*Severe Moderate Mild*
		Severe Moderate Mild
		Severe Moderate Mild
		Severe Moderate Mild
		Severe Moderate Mild
		Severe Moderate Mild

Reviewed by: _____

(Provider Signature)

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Adult Medical History Form

***Your Family Medical History** (Circle all that currently apply):

	Mother	Father	Sister	Brother	Son	Daughter
Coronary Heart Disease- Females(diagnosed before age of 65)	☐		☐			☐
Coronary Heart Disease- Males (diagnosed before age of 55)		☐		☐	☐	
Anemia	☐	☐	☐	☐	☐	☐
Anesthetic Problems	☐	☐	☐	☐	☐	☐
Autoimmune	☐	☐	☐	☐	☐	☐
Abnormal Bleeding	☐	☐	☐	☐	☐	☐
Blood Clotting Disorder	☐	☐	☐	☐	☐	☐
Brain Cancer	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐
Cervical Cancer	☐	☐	☐	☐	☐	☐
Colon / Rectal Cancer	☐	☐	☐	☐	☐	☐
Dialysis	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Kidney Cancer	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐
Polyposis, Familial adenomatous	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐
Seizures / Convulsions	☐	☐	☐	☐	☐	☐
Stroke /CVA	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Family Medical History: Unknown	☐					
Family medical History: Not significant	☐					

Family History of Breast Cancer	Family History of Ovarian Cancer	Family History of Colon Cancer
+Breast cancer, <50 yrs. old Circle: *Mother, Father, Sibling, Grandparent*	+ Ovarian Cancer & Ashkenazi Circle: *Mother, Father, Sibling, Grandparent*	+Colon Cancer, <60yrs old Circle: *Mother, Father, Sibling, Grandparent*
+Breast Cancer, bilateral Circle: *Mother, Father, Sibling, Grandparent*	+ Ovarian Cancer, at any age Circle: *Mother, Father, Sibling, Grandparent*	+FAP, Familial adeno. polyposis Circle: *Mother, Father, Sibling, Grandparent*
+Breast Cancer, > 2 different locations Circle: *Mother, Father, Sibling, Grandparent*	+Breast & Ovarian Cancer Circle: *Mother, Father, Sibling, Grandparent*	+ HPNCC, Non-hereditary polyposis Circle: *Mother, Father, Sibling, Grandparent*
+Breast Cancer, male at any age Circle: *Mother, Father, Sibling, Grandparent*		+ Turcot Syndrome Circle: *Mother, Father, Sibling, Grandparent*
+Breast & Ovarian Cancer Circle: *Mother, Father, Sibling, Grandparent*	**Family History of Other Cancers**	+Peutz-Jeghers Circle: *Mother, Father, Sibling, Grandparent*
+Breast Cancer & Ashkenazi heritage Circle: *Mother, Father, Sibling, Grandparent*	+ Melanoma & Pancreatic Cancer Circle: *Mother, Father, Sibling, Grandparent*	
+ BRACA Mutation Circle: *Mother, Father, Sibling, Grandparent*		

Reviewed by: _____

(Provider Signature)