Serenity Wellness Clinic
12570 SW 69th Avenue, Suite 101
Tigard, Oregon, US - 97223-2552

New Patient Paperwork (Rev0124)

Thank you for scheduling with me - I look forward to working with you to improve, maintain and monitor your health. Please complete the following questionnaire as best you can. There are very few items which are mandatory (marked with *), but the more information you can provide, the better I can serve you. If you would prefer to complete this information on paper, you may find a paper version on my website: doctorbijana.com/newpatients. If you aren't able to print the paperwork, please contact me by phone and a copy may be mailed to you prior to your initial visit. Parts of this questionnaire are widgets which pre-populate my EHR and the questions are not worded exactly as I would have. If there is a question which you find offensive, please accept my apologies. For those and for questions for which none of the answers apply to you, please leave that question blank and provide additional information in the space provided at the end of the form.

Personal Details

First Name *

Last Name *

Date of Birth *

Gender ☐ Male ☐ Female ☐ Unknown

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker ☐ current status unknown ☐ Unknown if ever smoked

Primary Contact Details

Caregiver First Name

Caregiver Last Name

Email *

Home Phone _____

Mobile Phone _____

Work Phone _____

Fax _____

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 * _____

Address Line2 _____

City * _____

Country * _____

State * _____

Zip code * _____

Postbox No _____

Emergency Contact Name _____

Emergency Contact Number _____

Extn _____

Insurance Information

I bill insurance and am in network with most major insurance carriers. If you have any questions about which insurance companies I work with, please visit my website and review doctorbijana.com/insurance-information/ and/or call your insurance company for details. There is a form linked on the above referenced webpage which can guide you in what to ask your insurance company.

Will we be billing insurance for your visit? * ☐ Yes ☐ No

Insurance Company: _____

Who is the primary insured? _____

If you are not the primary insured, what is the date of birth of the primary insured? (For example, your parent or spouse) _____

Insurance ID number: _____

Insurance Group number: _____

What is the address on the back of the card to which bills should be sent?

Please provide the phone number on the back of the card. If there are multiple phone numbers, please list the number which is indicated for providers, claims or billing.

Do you have secondary insurance coverage? If so, please also bring that card to your visit.

☐ Yes ☐ No

Reason for Visit

What is the primary reason for your visit today? *

In addition to the above, what are your other most important health concerns?

Are you working with other healthcare providers on this issue? Are you established with a primary care provider? Please indicate those providers along with either location or phone number.

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

Allergies

Allergies	Type	Severity	Reactions

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Past Medical History

Please indicate any major past medical interventions including evaluations (xrays, CT, MRI, EKG, Labs) for your chief complaint; and past surgeries or past hospitalizations. Include the date or year of the event to the best of your ability.

Family Medical History

Do you have access to family medical history?

☐ Yes ☐ No

Are you aware of any of the following conditions running in your family and/or of your immediate family members having any of the following conditions?

☐ Addiction ☐ Alzheimer's ☐ Arthritis
☐ Autoimmune disease ☐ Cancer ☐ Diabetes
☐ Epilepsy ☐ Glaucoma
☐ Heart attack ☐ High blood pressure ☐ High cholesterol
☐ Kidney disease
☐ Mental Illness ☐ Osteoporosis ☐ Stroke

Do you have any other known genetic condition? Please describe.

Please use this space for more information about family history as needed.

Lifestyle Factors

Who do you live with?

☐ Spouse ☐ Parents ☐ Children
☐ Friends ☐ Alone

Which of the following best describes you?

☐ Employed outside the home, full time ☐ Employed outside the home, part time ☐ Stay at home parent or house-holder
☐ Student ☐ Retired ☐ Currently unemployed

How much time do you spend in your primary occupation?

How would you describe your diet? Please select all that apply.

☐ Healthy ☐ Unhealthy ☐ Low carb
☐ Keto ☐ Paleo ☐ Vegetarian
☐ Vegan ☐ Plant-based ☐ Whole food plant based
☐ Low oil ☐ Low sugar ☐ Lacto-ovo Vegetarian
☐ Pescatarian ☐ Dairy free ☐ Gluten free
☐ Grain free ☐ Sugar free

Do you think you drink enough water? ☐ Yes ☐ No

Do you drink coffee? ☐ Yes ☐ No

Do you drink soda? (regular or diet) ☐ Yes ☐ No

Do you drink alcohol more than 2 drinks/week? ☐ Yes ☐ No

Have you been treated for alcoholism? ☐ Yes ☐ No

Have you been treated for drug dependence? ☐ Yes ☐ No

Do you regularly pray or meditate? ☐ Yes ☐ No

Do you exercise? How? How much?

Do you sleep well or have trouble sleeping? Do you feel refreshed after sleeping?

Do you have supportive social relationships? With whom are you closest?

Do you have a history of major physical trauma such as a car accident, concussion or other injury? ☐ Yes ☐ No

Do you have a history of major emotional trauma? ☐ Yes ☐ No

Do you have a history of abuse? ☐ Yes ☐ No

Preventive Care

Please list the dates of your most recent preventive care screenings as applicable. For those questions which do not apply to you, please simple leave them blank.

When was the last time you saw a healthcare provider? _____

When was your last annual physical? _____

When was your last screening bloodwork? _____

When was your last PAP? Results? _____

When was your last mammogram?
Results? _____

When was your last colonoscopy?
Results? _____

When was your last DEXA (bone density) scan? Results? _____

When was your last prostate exam or PSA? _____

Review of Systems

For the following section, please indicate symptoms which you are experiencing related to your chief complaint and other symptoms which you consider current. For example, most people have had a headache at some time in their life, but you should mark headache if this is an ongoing or current problem for you. Each system has a space where you can provide more information.

General or Multi-System Symptoms *

- ☐ Anemia
- ☐ Autoimmune disease
- ☐ Brain fog
- ☐ Change in thirst or appetite
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Frequent infections
- ☐ Inflammation
- ☐ Sleep issues
- ☐ Slow wound healing
- ☐ Stress
- ☐ Weight gain
- ☐ Weight loss
- ☐ None of these

Notes:

Temperature *

- ☐ Run hot
- ☐ Run cold
- ☐ Cold hands/feet
- ☐ Intolerant to hot
- ☐ Intolerant to cold
- ☐ Excessive sweating
- ☐ Lack of sweating
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Raynaud's phenomenon
- ☐ None of these

Notes:

Mental - Emotional *

- ☐ Anxiety/nervousness/tension
- ☐ Depression
- ☐ Depression, seasonal
- ☐ Easily stressed
- ☐ Memory problems
- ☐ Mood swings
- ☐ Poor concentration
- ☐ Suicidality - thoughts or attempt
- ☐ Treatment for emotional problems
- ☐ None of these

Notes:

Endocrine - Hormonal *

- ☐ Diabetes
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Goiter
- ☐ High thyroid (hyperthyroidism)
- ☐ Low blood sugar
- ☐ Low thyroid (hypothyroidism)
- ☐ Menopausal symptoms
- ☐ None of these

Notes:

Neurological *

- ☐ Balance issues
- ☐ Loss of bladder continence
- ☐ Loss of bowel continence
- ☐ Muscle weakness, general
- ☐ Muscle weakness, local
- ☐ Numbness
- ☐ Paralysis
- ☐ Seizures
- ☐ Tingling
- ☐ Tremor
- ☐ None of these

Notes:

Hair Skin and Nails *

- ☐ Acne
- ☐ Boils
- ☐ Changes in nails
- ☐ Color changes
- ☐ Easy bruising
- ☐ Hair loss or thinning
- ☐ Hives
- ☐ Itching
- ☐ Lumps or bumps
- ☐ New moles
- ☐ Rash
- ☐ Suspicious mole or other lesion
- ☐ None of these

Notes:

Head and Neck *

- ☐ Head ache
- ☐ Head injury
- ☐ Concussion
- ☐ Migraine
- ☐ Neck lumps
- ☐ Neck pain
- ☐ Neck stiffness, change in mobility
- ☐ Swollen glands in neck
- ☐ None of these

Notes:

Eyes *

- ☐ Blurry vision - new
- ☐ Blurry vision - corrected by glasses/contacts
- ☐ Cataracts
- ☐ Color blindness
- ☐ Double vision
- ☐ Dry eye
- ☐ Eye pain/strain
- ☐ Excessive tearing
- ☐ Glaucoma
- ☐ Spots in eyes
- ☐ None of these

Notes:

Ear Nose and Throat *

- ☐ Difficulty swallowing
- ☐ Earaches
- ☐ Hoarseness
- ☐ Impaired hearing
- ☐ Loss of smell
- ☐ Nosebleed
- ☐ Postnasal drip
- ☐ Ringing in ears
- ☐ Seasonal allergies
- ☐ Sinus congestion
- ☐ Sore throat
- ☐ Stuffy nose
- ☐ None of these

Notes:

Mouth *

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Cold or canker sores
- ☐ Copious saliva
- ☐ Difficulty chewing
- ☐ Dry mouth
- ☐ Jaw clicking or TMJ
- ☐ Sore tongue or lips
- ☐ Teeth grinding
- ☐ Tooth pain
- ☐ None of these

Notes:

Respiratory *

- ☐ Asthma
- ☐ COPD
- ☐ Cough - dry cough
- ☐ Cough - wet/productive cough
- ☐ Cough - including blood
- ☐ Difficulty breathing
- ☐ Pain on breathing
- ☐ Shortness of breath
- ☐ Symptoms worse lying down
- ☐ None of these

Notes:

Cardiovascular *

- ☐ Arrhythmia
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Heart palpitations
- ☐ High blood pressure
- ☐ History of blood clot
- ☐ History of stroke
- ☐ History of heart attack
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Swelling in leg or ankle, single
- ☐ Swelling in leg or ankle, both
- ☐ None of these

Notes:

Gastrointestinal *

- ☐ Abdominal pain
- ☐ Bloating/gas
- ☐ Blood in stool (or black stools)
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallbladder disease or removal
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Liver disease
- ☐ Nausea
- ☐ Ulcer
- ☐ Vomiting
- ☐ None of these

Notes:

Urination *

- ☐ Difficulty initiating urination
- ☐ Dribbling
- ☐ Inability to hold urine
- ☐ Incomplete emptying
- ☐ Frequent infections
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Painful urination
- ☐ Urgent urination
- ☐ None of these

Notes:

Musculoskeletal *

- ☐ Change in range of motion
- ☐ Muscle spasms or cramps
- ☐ Recent injury
- ☐ Old injury
- ☐ Pain in neck
- ☐ Pain in mid to upper back
- ☐ Pain in shoulder
- ☐ Pain in arm including elbow and wrist
- ☐ Pain in hands/fingers
- ☐ Pain in lower back
- ☐ Sciatica
- ☐ Pain in hips
- ☐ Pain in knees
- ☐ Pain in ankles
- ☐ Pain in feet
- ☐ None of these

If you have a history of broken bone or surgical implants that are impacting your current complaint, please describe here:

Sexual health

Sexual activity with

- ☐ Male
- ☐ Female
- ☐ Both
- ☐ None

Please indicate any concerns or symptoms you are having regardless of gender and anatomy.

- ☐ Genital pain
- ☐ Pelvic pain
- ☐ Pain with sexual activity
- ☐ Sexual difficulties (other than pain)
- ☐ Reduced libido
- ☐ Sores
- ☐ Discharge
- ☐ Suspected STI
- ☐ History of STI
- ☐ Fertility issues
- ☐ None of these

If you have a menstrual cycle, please indicate if any of the following could describe your period or menstrual cycle.

- ☐ Bleeding between
- ☐ Excessive clotting
- ☐ Heavy
- ☐ Irregular
- ☐ Painful during
- ☐ Painful between
- ☐ Skipped
- ☐ Menses affects other symptoms
- ☐ None of these

Have you ever been pregnant?

- ☐ Yes
- ☐ No

If you have a history of pregnancy, please describe any complications you experienced during pregnancy or postpartum.

Please use the following space to add any additional information or clarifications on any topic.