Medical Office Building

1100 Goethals Drive, Richland

DIRECTIONS

From **I-182**

Take **George Washington Way** (Exit 5B)

Turn left on **Swift Boulevard**

Turn right on **Goethals Drive** (third right)

1100 Goethals Drive is one block on the right

First Floor

Infectious Disease
(509) 942-2360

Neuroscience Center
(509) 942-3080

Second Floor

Ear, Nose and Throat
(509) 942-3288

Endocrinology
(509) 942-3288

Foot and Ankle
(509) 942-3288

General and Colorectal Surgery
(509) 942-3288

Nephrology
(509) 942-3288

Urology
(509) 942-32880

Tri-Cities Laboratory
(509) 946-4887

Third Floor

Inland Cardiology
(509) 942-3272

Cardiothoracic Surgery
(509) 942-3095

Interventional Radiology
(509) 942-3095

Pulmonology
(509) 942-3095

Vascular Surgery
(509) 942-3095

KADLEC | CLINIC

www.kadlecclinic.org

Your answers to this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do no answer it. If you cannot remember specific details, please provide your best guess. Thank you!!

Name:_____ Date of Birth**:** _____
Height**:** _____ Weight: _____

REASON FOR VISIT**:** _____

Previous treatment for this problem:_____
_____

Drug Allergies**:** please list reaction ○ NKDA (No known drug allergies)
Type/Drug: _____ Reaction: _____
Type/Drug: _____ Reaction: _____
Type/Drug:_____ Reaction: _____
Type/Drug: _____ Reaction: _____
Type/Drug: _____ Reaction: _____

PRESENT MEDICATIONS: (please include any aspirin, over the counter vitamins, herbs and other supplements)
☐ Not taking any medication at this time

MEDICATION/DRUG NAME DOSE (mg) FREQUENCY (times per day)

_____

_____

_____

_____

_____

_____

Please check any medical conditions that may apply:

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Transfusion
- ☐ Brain Tumor
- ☐ Cancer
- ☐ Chemical Dependence
- ☐ Congestive Heart Failure
- ☐ COPD/ Smokers Lung
- ☐ Crohn's Disease
- ☐ CVA Stroke
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Domestic Violence
- ☐ DVT-Blood Clots
- ☐ Erectile Dysfunction
- ☐ GERD
- ☐ Gout
- ☐ Heart Problems
- ☐ Heart Attack
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Stones
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ UTI-Recurrent

Surgical History:

Date Type of Surgery Location

Social History:

Are you:

☐ Working ☐ Full-Time ☐ Part-Time ☐ Modified Duty

Occupation:_____Employer:_____

☐ Retired Previous Occupation:_____
☐ Disabled Previous Occupation:_____

Marital Status: ☐ Single ☐ Partner/Married ☐ Divorced ☐ Widowed ☐ Other_____

Is there a possibility you may be pregnant? ☐ Yes ☐ No If yes, how many weeks?_____

Spouse/Partners Name:_____
Number of Children/Ages:_____

Family History:

☐ Adopted

Mother: ☐ Alive ☐ Deceased _____Age (Now or at Death)
Cause of Death/Medical problems: _____
Father: ☐ Alive ☐ Deceased _____ Age (Now or at Death)
Cause of Death/Medical problems: _____

Please indicate family members (parent, sibling, maternal or paternal grandparent, aunt or uncle) with any of the following conditions:

☐ *Cancer*_____
☐ Heart Disease_____
☐ High Blood Pressure_____
☐ Malignant Hyperthermia_____
☐ Aneurysms_____
☐ Stroke_____
☐ Diabetes_____
☐ Epilepsy_____
☐ Congenital Problems_____
☐ Brain Tumors_____
☐ Problems with Anesthesia_____
☐ Other_____

Have you had any of the following tests?:

Test	When?	Where?	Results:
☐ MRI			
☐ Head CT			
☐ EEG			
☐ EMG			
☐ Spinal Tap			
☐ Labs			
☐ Other			
☐ Other			

PLEASE CHECK ALL THAT APPLY

CONSTITUTION
- ☐ Activity Change
- ☐ Appetite Change
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected Weight Change

HENT
- ☐ Neck Pain
- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Sinus Pressure
- ☐ Dental Problems
- ☐ Drooling
- ☐ Mouth Sores
- ☐ Trouble Swallowing
- ☐ Voice Change

EYES
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Photophobia
- ☐ Visual Disturbance

RESPIRATORY
- ☐ Cough
- ☐ Shortness of Breath

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations

GI
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY
- ☐ Difficulty Urinating
- ☐ Dysuria
- ☐ Frequency

MUSCULOSKELETAL
- ☐ Arthralgia's (Joint Pain)
- ☐ Back Pain
- ☐ Gait Problem
- ☐ Joint Swelling
- ☐ Myalgia's (Muscle Pain)

SKIN
- ☐ Rash

NEUROLOGICAL
- ☐ Dizziness
- ☐ Facial Asymmetry
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope (Fainting)
- ☐ Tremors
- ☐ Weakness

HEMATOLOGIC
- ☐ Bruises/Bleeds Easily

PSYCHIATRIC
- ☐ Agitation
- ☐ Confusion / Memory Loss
- ☐ Decreased Concentration
- ☐ Dysphonic (Changing) Mood / Depression
- ☐ Hallucinations
- ☐ Nervous/Anxious
- ☐ Sleep Disturbance