Health History Form

Patient Name: _____ Date of Birth:___/___/____

What concerns do you have about your health that you want to discuss today?

Have you been seen at the following for any type of visit, treatment, testing or hospitalization?

OHSU **Adventist Health** **Legacy** **Kaiser** **Other:_____**

Preventative Services: (please list when and where the procedure was done)

Colonoscopy:_____ Pneumonia vaccine: _____
Physical Exam: _____ Shingles vaccine:_____
Blood test/Cholesterol Level:_____ Flu shot: _____
Prostate check: _____ Tetanus booster: _____
Female: Pap test in the past 3 years? _____
Female: Mammogram in last 2 years?_____

Current Medications

Medication	Dose	Frequency	When started?

Any Known Drug Allergies? Yes / No Please List: _____

_____ _____

Medical History: Have you ever had: (Circle all that apply)

Anemia
Anxiety
Arthritis
Asthma
Blood Transfusion
Cancer
Cataracts
CHF
Clotting Disorder
COPD
Depression
Diabetes
Emphysema
Environmental Allergies
GERD
Glaucoma
Heart Murmur
HIV/AIDS
Hyperlipidemia
Hypertension
Kidney Disease
Meningitis
Myocardial Infarction
Nerve/Muscle disease
Osteoporosis
Seizures
Stickle cell Anemia
Stroke
Substance Abuse
Tuberculosis

Other: _____

~OVER~

List all surgeries and serious illness:

Surgery/Serious Illness	Year	Hospital / Any Complications

Family History

Major medical problems that would be worrisome for your own medical risk including mental health, or are they general healthy and well.

	Age	**Living**	**Age at Death**	**Cause of Death or Current Condition**
Mother	_____	Yes/No	_____	_____
Father	_____	Yes/No	_____	_____
Brother(s)	_____	Yes/No	_____	_____
Sister(s)	_____	Yes/No	_____	_____

Is there any history of **Diabetes**: Yes or No Who? _____

Is there any family history of **early cardiovascular disease** Yes or No Who? _____

Is there any family history of **cancer**? Yes or No If so, who and what type?

1. _____ 3. _____
2. _____ 4. _____

Health / Safety History

Marital Status: _____ Occupation: _____

Are you sexually active? **Y N** Partner(s) Male___ Female____ Birth control method_____

Do you drink alcohol? **Y N** Drinks/Week _____

Illicit drug use? ___Never ___Recent ___Remote ___Current

Do you smoke? **Y N** If yes, age you started smoking? _____ Year you quit?_____

Packs per day? _____ Smokeless tobacco _____

Are you interested in quitting? **Y N**

Have you completed an Advance Directive or POLST? **Y N**

Please circle any new or worrisome symptoms (In the past 4 weeks):

General: Fatigue Fevers	**Hematology**: Abnormal bleeding
Vision: Double vision	**Neuro**: Seizures Loss of consciousness
Head & Neck: Change in hearing Ear pain	**Endocrine**: Fatigue High level of thirst
Pulmonary: Wheezing	**Musculoskeletal**: Joint swelling
Cardiac: Chest pain Rapid heartbeat	**Mental health**: Anxiety Memory problems
Gastrointestinal: Nausea Vomiting	**Skin & Hair**: Sores that grow Rash
GU: Blood in urine	**Other:**

Thank you for taking the time to fill out this form