Providence Medical Group/Camas
3101 SE 192nd Ave, Ste 106 - Vancouver, WA 98683
Phone: 360-553-7400 - Fax: 360-553-7450

Health History Questionnaire

Date of visit: _____

Full Name: _____ Birthdate: _____ Age: _____ Sex: Male Female

Present symptoms / what brings you in today?: 1._____ 2. _____ 3. _____

Current Medications:

Name and Strength	How many times do you take per day?	How long have you taken this medication?

Known Drug Allergies or Sensitivities:

Name of Medication /Item:	Reaction:

Past Medical History and Current Problems:

1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

Social History: Student / Retired / Unemployed /Employed- Occupation: _____

Years of Education / Highest Degree: _____ Employer:_____

Do you have any children? Name and age:_____

Marital Status: Married/Single/In relationship/Widowed/Divorced/Separated/Domestic partner/ Other: _____

Other adults currently living in the same home? Name, age, relation: _____

Currently are you experiencing any of the following symptoms? **Please circle if yes**:

Fevers / chills / night sweats	Shortness of breath- day or night	Urinary hesitancy
Fatigue	Shortness of breath with exercise	Frequent nighttime urination
Loss of appetite	Swelling in legs or feet	Inability to hold urine
Weight gain / loss greater than 15 lbs	High blood pressure	Sexual difficulties / decreased desire
Blurred vision / double vision	Heart murmur	Genital sores
Eye irritation / discharge	Cough / wheezing	Back / neck pain
Eye pain / redness / dryness	Coughing up blood	Muscle pain / cramps / weakness
Vision loss	Nausea / vomiting	Morning muscle stiffness
Light / noise sensitivity	Persistent diarrhea	Skin rash / redness / hives / bumps
Ear pain / discharge	Increasing constipation	Headache
Ringing in the ears / Hearing loss	Heartburn	Depression / anxiety
Sneezing / nasal congestion	Changes in bowel habits	Memory loss
Frequent sore throat	Pain after eating	Trouble sleeping
Nosebleeds	General abdominal pain	Suicidal or homicidal thoughts
Throat hoarseness	Vomiting blood	Hallucinations / paranoia
Difficulty swallowing	Blood in stools / black stools	Cold / heat intolerance
Chest pain	Pain / burning with urination	Frequent or difficult urination
Sudden changes or irregular heart beat	Vaginal discharge	Excessive or easy bruising / bleeding
Fainting or dizziness	Urinary frequency / urgency	Enlarged lymph nodes

PLEASE COMPLETE BOTH SIDES OF FORM

List all Surgeries or Major Procedures:

Year	Reason / Facility

Tobacco use: Never / Current /Quit, date: _____ ____packs per day for _____ years Interested in quitting: Y N

Other tobacco use: Pipe/Cigar/Snuff/Chew _____ per day / week / month / year for ____ years Quit, date: _____

Alcohol use: Current/Occasional-Social/Quit, date: _____ Number of drinks per week / month / year:_____

Are you or anyone else concerned about your alcohol use? Y N

Drug use: Never/ Current- daily/ Social Settings Only Type(s): _____ #times per week / month / year:_____

Sexual Activity: Have you had sex? Y N Number of partners in lifetime: _____ Birth control method: _____

Do you prefer to have sex with men, women or both? History of sexually transmitted disease? N Y, type: _____

List all Overnight or Inpatient Hospitalizations:

Year	Reason

Caffeine intake: ___none ___coffee/tea: 8oz cups/day_____ __soda: # per day_____ ____chocolate: oz per day _____

Weight: Are you satisfied with your current weight? Y N

Diet: How would you rate your diet? Good Fair Poor Do you take supplements or vitamins? Y N (on med list above?)

Exercise: Do you exercise regularly? Y N What kind: _____ How long (minutes)? _____ How often: _____

Safety: Wear seatbelt consistently? Y N Do you have a gun in your home? Y N If yes- are they stored safely? Y N

Is violence at home a concern? Y N Has this ever been a concern? Y N Please explain: _____

Immunizations and Screenings: please list actual or approximate (month/year) dates

Last physical: _____ Last colonoscopy: _____ Shingles shot: _____

Pneumovax (pneumonia vaccine): _____ Flu shot: _____ Tetanus shot: _____

WOMEN ONLY:

When was your last PAP test? _____ History of any abnormal PAPs? Yes or No Treatment? _____

When was your last mammogram? _____ When was your last bone density screening? _____

# of Pregnancies _____ # of Deliveries _____ # of Abortions_____ # of Miscarriages _____

1st day of last period _____ Age at 1st period _____ Regular or irregular Average length (days) _____

Do you have any concerns about your periods? No Yes; explain: _____

Do you have any concerns about menopause? No Yes; explain: _____

Family history: please indicate the current status of your immediate family members ***PLEASE COMPLETE SECTION***

	Alive	Deceased	Age (now/at death)	Comments/Medical Problems
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister(s) #___	_____	_____	_____	_____
Brother(s) #__	_____	_____	_____	_____

Family Medical History (check if you or your family has a history of the following):

You	Family		You	Family		You	Family	
☐	☐	Alcoholism	☐	☐	Thyroid disorder- High / Low	☐	☐	Heart disease
☐	☐	Blood disorder	☐	☐	Lung cancer	☐	☐	High blood pressure
☐	☐	Asthma	☐	☐	Colon cancer	☐	☐	Liver disease
☐	☐	Diabetes	☐	☐	Breast cancer	☐	☐	Lung disease
☐	☐	Psychiatric condition	☐	☐	Female cancer: _____			Smoking related? Y N
☐	☐	Depression	☐	☐	Other cancer: _____	☐	☐	Clot in leg / lung
☐	☐	Suicide attempt	☐	☐	Ulcer	☐	☐	Stroke