PROVIDENCE
Medical Group
Hillsboro

Patient Name:	Date of Birth: Place of Birth:	Age:	Sex:	Today's Date:

Patient & Family Medical History: Has patient or immediate family member ever had?
(Please check appropriate box.)

	Patient	Family Member	Relationship to Patient
Alcohol/Drug Abuse	☐	☐	_____
Asthma	☐	☐	_____
Arthritis	☐	☐	_____
Anemia	☐	☐	_____
Abnormal Pap Smear	☐	☐	_____
Anxiety	☐	☐	_____
Breast Problem	☐	☐	_____
Bleeding Problem	☐	☐	_____
Blood Transfusion	☐	☐	_____
Cancer (specify type)	☐	☐	_____
COPD/Emphysema	☐	☐	_____
Depression	☐	☐	_____
Diabetes	☐	☐	_____
Hay fever (allergies)	☐	☐	_____
Heartburn	☐	☐	_____
Heart Attack	☐	☐	_____
Heart Murmur	☐	☐	_____
Heart Problem (other)	☐	☐	_____
Hepatitis	☐	☐	_____
High Blood Pressure	☐	☐	_____
High Cholesterol	☐	☐	_____
HIV	☐	☐	_____
Kidney Problem	☐	☐	_____
Mental Health Problem	☐	☐	_____
Migraine Headaches	☐	☐	_____
Osteoporosis (brittle bones)	☐	☐	_____
Pregnancy related problem	☐	☐	_____
Seizures/Epilepsy	☐	☐	_____
Sexually Transmitted Disease	☐	☐	_____
Stroke/TIA	☐	☐	_____
Stomach Ulcer	☐	☐	_____
Thyroid Disease	☐	☐	_____
Other (please specify):	☐	☐	_____

Obstetrical History:

Number of times pregnant _____
Number of premature babies _____
Number of living children _____
Number of full term babies _____
Number of abortions or miscarriages _____
Number of stillborn babies _____

Please list all surgeries you have had:

Surgery	Year	Hospital/Location

Please list all of your overnight hospitalizations:

Reason for hospitalization	Year	Hospital/Location

Medication/Food Allergies:

Medication	Reaction

Food	Reaction

Medications you are currently taking: (including birth control, over the counter and herbal meds.)
**If you brought your medication bottles or a list with you today you do <u>not</u> need to fill out this section*

Medication	Dose	Frequency

Preventative Health Care - Approximate dates of your last:

Pap Smear _____
Mammogram _____
Colonoscopy _____
Colon cancer screening _____
DEXA scan _____
Cholesterol blood test _____
Eye exam _____
Dental exam _____
Pneumonia vaccine _____
Tetanus vaccine _____
Flu vaccine _____
Hepatitis B vaccine _____
Shingles vaccine _____

Social History:

Marital Status: _____

How many children do you have?: _____

Occupation: _____ Spouse's Occupation: _____

Are you sexually active? Yes ☐ Not currently ☐ Never ☐

If active, are your sexual partners: Male ☐ Female ☐ Both ☐

Do you exercise regularly? **Y / N**

If so, what exercise do you do and how often?

Do you feel safe in your current relationship?

Have you completed an Advanced Directive or Living Will? **Y / N**

Current Use	Past Use
Do you currently smoke? **Y / N**	Have you smoked regularly in the past? **Y / N**
If yes, age you started smoking? _____	How many packs per day? _____
Packs per day? _____	When did you quit? _____
If so, how many years? _____	
Do you currently chew tobacco? **Y / N**	Have you chewed tobacco regularly in the past? **Y / N**
	If so, how many years did you chew? _____
	When did you quit? _____

Are you currently in recovery for alcohol or substance abuse? **Y / N**

Alcohol: One drink = 

12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or more
Men: How many times in the past year have you had 5 or more drinks in a day?	☐	☐
Women: How many times in the past year have you had 4 or more drinks in a day?		

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	☐	☐

Mood:	None	1 or more
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	☐	☐
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?		

Have you requested your previous physician's records? If not, please remember to ask for a Release of Records form while at the front desk.

Thank you for taking the time to fill out this form