Providence Medical Group/Molalla
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PROVIDENCE Medical Group Molalla

Patient Name:	Date of Birth: Place of Birth:	Age:	Sex:	Todays Date:

Patient's Medical History: Has patient ever had? (Circle the appropriate items.)

Alcohol/Drug Abuse	Emphysema	High Blood Pressure	Psychiatric
Asthma	Epilepsy	High Cholesterol	Seasonal Allergies
Cancer	Heart Disease	Infectious Disease	Stomach Disorders
Colitis	Headaches	Kidney Disease	Thyroid Disease
Diabetes			

Immediate Family's Medical History: Blood relatives who currently have or have ever had? (Circle the appropriate items.)

Alcohol/Drug Abuse	Emphysema	High Blood Pressure	Psychiatric
Asthma	Epilepsy	High Cholesterol	Seasonal Allergies
Cancer	Heart Disease	Infectious Disease	Stomach Disorders
Colitis	Headaches	Kidney Disease	Thyroid Disease
Diabetes			

Family History:

	Age(s)	Living?	Age at Death	Cause of Death or Current Condition
Father	_____	**Y/N**	_____	_____
Mother	_____	**Y/N**	_____	_____
Brothers	_____	**Y/N**	_____	_____
Sisters	_____	**Y/N**	_____	_____
Child(ren)	_____	**Y/N**	_____	_____

List All Surgeries and Serious Illnesses:

Surgery/Serious Illness	Year	Hospital/Location
_____	_____	_____
_____	_____	_____

Medication/Food Allergies:

Medication	Reaction
_____	_____
_____	_____

Food	Reaction
_____	_____
_____	_____

(Please see other side)

Medications you are currently taking: (including birth control, over the counter, and herbal meds.)

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dates of your last:

Blood test/Cholesterol level: _____ EKG: _____
Pap Smear: _____ Chest X-ray: _____
Prostate Check: _____ Mammogram: _____
Physical Exam: _____ Tetanus Booster: _____
Glaucoma Check: _____ Pneumovax: _____
Sigmoidoscopy/stool check: _____ Skin Test for TB: _____

Social History:

Marital Status: _____ Occupation: _____ Spouse's Occupation: _____

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

Illicit drug use? **Never_____** **Recent_____** **Remote_____** **Current_____**

How much caffeine do you drink? (average number of drinks per day)
None **1** **2** **3** **4** **>5**

How much alcohol do you drink? (average number of drinks per day)
None **Rare<1** **Moderate 1-2** **High >2**

Do you exercise? **None** **Occasional** **Moderate** **Frequent**

Seat Belt Use? **Y or N** Smoke Detector in home? **Y or N**
Bike Helmet Use? **Y or N** Fire Extinguisher in home? **Y or N**

Have you completed and Advance Directive or Living Will? **Y or N**

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