



Oregon Medical Group Medical History Form

Date _____ Patient Name _____ Age _____ Date of Birth _____
 Other Physicians involved in my care _____
 Referred to this office by _____

What areas or issues would you like to discuss today: (Please limit to 3 items)

1. _____ 2. _____
 3. _____

PREVENTATIVE HEALTH STATUS:

Date of last physical exam: _____ Last eye exam: _____ Last dental exam: _____
 Have you ever had a colonoscopy or sigmoidoscopy? yes no When/Findings: _____
 Have you ever had a bone density test? yes no When/Findings: _____
 Do you have an Advance Directive for health care decisions? yes no

Last immunizations: (please give date of most recent vaccination or series completion date)

Tetanus: _____ Hepatitis B: _____ Hepatitis A: _____ HPV: _____ Influenza: _____
 Pneumonia: _____ Shingles: _____ TB skin test result: _____ Date: _____

FOR WOMEN ONLY:

Date of last period: _____ Last Pap: _____ Age periods began: _____ Age at start of menopause: _____
 Have you had a mammogram? yes no Most recent date _____ Result _____
 Birth control method: _____
 Have you had any pregnancies? yes no Total number _____ Miscarriages/Abortions _____
 Problems during pregnancies: _____

FOR MEN ONLY:

Have you had a PSA blood test and/or prostate exam? yes no Last Date _____ Result _____

SOCIAL HISTORY:

Occupation: _____ Former Regions of Residence: _____
 Marital Status: Single Married Domestic Partnership Divorced Widowed
 Living Situation: Alone Roommate Spouse Parents Significant Other With Children
 Have you been in a relationship where you were hurt, threatened or made to feel afraid? yes no
 Do you drink alcohol? yes no How many per week? _____ Quit/When _____
 Do you use tobacco? yes no How much/how long? _____ Quit/When _____
 Do you drink caffeine? yes no How much per day? _____
 Have you used drugs? yes no Which ones? _____ Quit/When _____
 Do you exercise? yes no Type: _____ How often? _____
 Do you follow a diet? yes no Please describe: _____

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PERSONAL MEDICAL HISTORY: Have you ever been diagnosed with the following? (Please circle)

Heart Disease:

- murmur
- angina / coronary disease
- congestive heart failure
- rheumatic fever
- valve replacement
- irregular heartbeat
- heart attack
- high blood pressure

Infectious Disease:

- AIDS or HIV positive
- MRSA infection
- tuberculosis
- sexually transmitted disease

Musculoskeletal:

- rheumatoid arthritis
- gout
- osteoarthritis
- fibromyalgia

Gynecological:

- abnormal pap
- endometriosis
- fibroids
- ovarian cysts
- irregular bleeding

Respiratory:

- asthma
- allergies / hay fever
- emphysema/COPD
- chronic bronchitis
- pneumonia
- asbestos exposure
- sleep apnea

Gastrointestinal:

- ulcers
- colon polyps
- gallstones
- hiatal hernia
- hepatitis, type _____
- hemorrhoids
- irritable bowel syndrome
- colitis
- diverticulosis
- gastrointestinal bleeding

Kidney/Bladder:

- stones
- prostate disorder
- incontinence
- infection

Mental Health/Neurologic:

- anxiety
- depression
- alcoholism
- drug abuse
- other mental illness
- migraines/headaches
- stroke
- seizures
- paralysis

Metabolic/Nutrition:

- diabetes
- high cholesterol
- anemia
- thyroid problem
- bleeding disorder

Cancer:

- breast cancer
- cervical cancer
- ovarian cancer
- colon cancer
- skin cancer
- prostate cancer
- other cancer (type) _____

None of the above

Have you ever had a blood transfusion? yes no If yes, when? _____

Childhood Illnesses: _____

Hospitalizations, operations, serious illnesses or injuries: (omit pregnancies)

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

Present Medications: (Include birth control pills and non-prescriptive items such as vitamins, aspirin, herbs, etc.)

	<u>Name</u>	<u>Dose</u>	<u>Times/Day</u>		<u>Name</u>	<u>Dose</u>	<u>Times/Day</u>
1.	_____	_____	_____	5.	_____	_____	_____
2.	_____	_____	_____	6.	_____	_____	_____
3.	_____	_____	_____	7.	_____	_____	_____
4.	_____	_____	_____	8.	_____	_____	_____

Drug Allergies:

	<u>Medication</u>	<u>Type of Reaction</u>		<u>Medication</u>	<u>Type of Reaction</u>
1.	_____	_____	3.	_____	_____
2.	_____	_____	4.	_____	_____

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FAMILY HISTORY

Relation	If Living: Age	If Deceased: Age at Death	Cause
Father			
Mother			
Brother or sister			
1.			
2.			
3.			
4.			
5.			

Has any of your immediate family ever had: (if yes, indicate relationship and age of onset)

Allergy/Asthma	Arthritis/Gout
Cancer	Depression
Diabetes	Epilepsy/Seizures
Glaucoma	Heart Disease/Coronary Artery Disease
High Blood Pressure	Liver Disease
Kidney Disease	Mental Illness
Alcohol/Substance Abuse	Migraine Headaches
Overweight	High Cholesterol
Stroke	Thyroid Disease
Tuberculosis	Ulcers
Bleeding Disorder	Colon Polyps

Other family medical history: _____

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REVIEW OF SYSTEMS: Check any of the following symptoms you have experienced WITHIN THE PAST YEAR

GENERAL:

- change in heat & cold tolerance
- persistent fever
- chills/cold intolerance
- excess appetite
- increased thirst
- lack of appetite
- night sweats
- swollen glands
- unusual weakness
- unusual fatigue
- weight change
increase _____
decrease _____
- Other _____
- None of the above**

ALLERGY:

- sneezing
- environmental allergy
- food allergy _____
- Other _____
- None of the above**

SKIN:

- ulcers
- bruise easily
- change in skin or mole
- dryness of skin
- rash or hives
- nail change
- unusual hair loss
- Other _____
- None of the above**

EYES:

- eye pain
- blind spells (in one eye)
- change in vision
- contact lenses
- eye infection
- wear glasses
- Other _____
- None of the above**

EARS/NOSE/THROAT:

- earache
- hearing loss
- ear infection or drainage
- ringing in ears
- bleeding gums
- hoarseness
- neck swelling/lumps
- sores in mouth
- nose bleeds
- nasal polyps
- sinus trouble
- Other _____
- None of the above**

BREASTS:

- discharge/bleeding
- nipple changes
- lump
- pain
- Other _____
- None of the above**

HEART:

- white, blue or purple discoloration of hands or feet
- calf pain when walking
- chest discomfort/pain
- irregular heart beat
- racing or fluttering heart
- swollen feet or ankles
- varicose veins
- Other _____
- None of the above**

LUNGS:

- shortness of breath
- persistent cough
- wheezing
- cough up blood
- cough up phlegm
- difficulty breathing
- None of the above**

GASTROINTESTINAL:

- belching
- bloody or black stools
- change in stools
- constipation
- difficult swallowing
- excessive gas
- food intolerance
- heartburn/esophageal reflux
- hemorrhoids
- loose bowels/diarrhea
- nausea
- recurrent abdominal pain
- vomiting
- Other _____
- None of the above**

URINARY:

- change in urinary stream
- blood in urine
- difficulty urinating
- frequency
- leaking urine
- pain or burning on urination
- unusually large volumes of urine
- up at night to urinate? how often? _____
- incontinence
- sexual difficulty
- Other _____
- None of the above**

FEMALE:

- heavy menstrual bleeding
- irregular menstrual periods
- discharge
- premenstrual symptoms
- Other _____
- None of the above**

BONES AND JOINTS:

- back or neck pain
- cramps in muscles
- painful or stiff joints
- pain down backs of legs
- pain in legs with walking
- swelling in legs
- redness of joints
- Other _____
- None of the above**

MOOD/MENTAL

HEALTH:

- depressed or sad
- irritable or angry
- anxious, tense, or worried
- fearful
- sleep problems
- loss of interest in activities
- fatigue
- suicidal thoughts
- compulsive behaviors
- concentration/memory problems
- marital, family or work problems
- stress
- Other _____
- None of the above**

NEUROLOGIC:

- coordination problems
- difficulties in speaking
- dizziness
- fainting spells
- frequent headaches
- loss of balance
- loss of sensation
- muscle weakness
- numbness or tingling
- Other _____
- None of the above**

For Clinician Use

Reviewed by _____ Date _____