3170 State Street
Medford, OR 97504-8450
(541) 864-8900

Med Rec #: ____________________

Please fill out all below:

Name: ____________________

Birthdate: ____________________ Age ______

Phone (H) ______________ (W) ______________

Date ____________________

Referring physician ____________________

Occupation (past and present) ____________________ PCP ____________________

Reason for coming to the Clinic ____________________

Marital Status ____________ Next of Kin ____________________ Phone # ______________

PAST MEDICAL HISTORY: Have you had any of the following problems?

Medical Illnesses

- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Cholesterol problem
- ☐ Lung disease
- ☐ Ulcers
- ☐ Brain or nerve disease (stroke)
- ☐ Liver disease or hepatitis
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Cancer ______________
- ☐ Blood clots or phlebitis
- ☐ Depression/Anxiety
- ☐ Kidney disease/stones
- ☐ Acid reflux or hiatal hernia
- ☐ Migraine
- ☐ Environmental allergies
- ☐ Seizures
- ☐ Asthma
- ☐ Tuberculosis or abnormal skin test
- ☐ Osteoporosis
- ☐ Thyroid disorder
- ☐ Sexually transmitted disease
- ☐ Other ______________

Operations/Hospitalizations (includes tonsillectomy and appendectomy)

Date	Operation/Hospitalization	Complications

Severe Accidents and Injuries

____

Allergies and Adverse Medication Reactions (please list reaction)

____

Tobacco Use? ☐ No ☐ Yes Pkgs/day ______ # years ______ Quit? ______ Year quit ______

Alcohol Use? ☐ No ☐ Yes Drinks/day ______ Drinks/week ______ ☐ Beer ☐ Wine ☐ Hard liquor

Have you used recreational drugs? ☐ No ☐ Yes

Date of last use? ______________

Last menstrual period ______________ Last pap smear ______________ Last mammogram ______________

Number of pregnancies ______________ Number of births ______________ ☐ Contraception ______________

Including vasectomy ______________

☐ Irregular periods ☐ Abnormal pap smear ☐ Painful periods ☐ Heavy periods Tubal ligation ______________

MEDICATIONS CURRENTLY TAKEN regular or occasionally. Include vitamins, birth control pills, sleeping pills, pain pills, laxatives, aspirin – with dosage.

____

____

Glasses milk/day? ______________ Last osteoporosis scan ______________ Calcium supplements (mg/day)? ______________

Flu shot ☐ No ☐ Yes When ______________ How often do you exercise? ______________

Tetanus booster ☐ No ☐ Yes When ______________ What is your workout? ______________

Pneumonia vaccine ☐ No ☐ Yes When ______________ ______________

Hepatitis B vaccine ☐ No ☐ Yes When ______________ Date of last colonoscopy? ______________

Gardasil vaccine ☐ No ☐ Yes When ______________ Date of last endoscopy? ______________

SEE REVERSE SIDE

HEALTH HISTORY (ADULT)

HEALTH HISTORY (ADULT)

FAMILY HISTORY

	Age of death	Age if alive	General health; major health problems & illnesses, OR age and cause of death
Mother			
Father			
Brothers			
Sisters			

Significant Illness in Grandparents, Cousins, Aunts, Uncles or Children?

____

____

Check if any of these illnesses run in the family.

	No	Yes
Osteoporosis	☐	☐
Diabetes	☐	☐
Alcoholism	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Thyroid Disease	☐	☐
Ulcers	☐	☐
Mental Illness	☐	☐
Blood Clots	☐	☐
High Blood Pressure	☐	☐
TB	☐	☐

REVIEW OF SYSTEMS: Do you have, or have had in the past month, any of the following? (Place a check mark next to those you have experienced).

General
- ☐ Recent fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Loss of energy
- ☐ Trouble sleeping

Skin
- ☐ Rashes
- ☐ Changes in mole

Blood
- ☐ Easy bruising
- ☐ Transfusions

Nose and Mouth
- ☐ Tooth pain
- ☐ Sore throat
- ☐ Sinus pain
- ☐ Nasal congestion

Breasts
- ☐ Discharge from nipples
- ☐ Lumps
- ☐ Breast pain

Cardiovascular
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Varicose veins

Pulmonary
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Cough up blood

Digestive
- ☐ Poor appetite
- ☐ Gas or heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain or cramping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Rectal bleeding

Genitourinary
- ☐ Burning on urination
- ☐ Bloody urine
- ☐ Incontinence
- ☐ Infections
- ☐ Difficulty urination
- ☐ Urination at night: # times ____________
- ☐ Multiple sexual partners

Skeletal
- ☐ Fractures
- ☐ Arthritis
- ☐ Back or neck pain

Brain and nerves
- ☐ Dizziness
- ☐ Blackouts
- ☐ Headaches
- ☐ Depression
- ☐ Anxiety, excessive worry

Is there anyone that you're afraid of?_________

Source of stress?_________________________

Do you have an Advanced Directive for end-of-life?______________________________