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.)

Name	**Dose**	**Times/Day**	**Name**	**Dose**	**Times/Day**
1. _____	_____	_____	**5.** _____	_____	_____
2. _____	_____	_____	**6.** _____	_____	_____
3. _____	_____	_____	**7.** _____	_____	_____
4. _____	_____	_____	**8.** _____	_____	_____

Drug Allergies:

Medication	**Type of Reaction**	**Medication**	**Type of Reaction**
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**