West Linn Primary Care

Health History Questionnaire

Name:_____ Date of Birth:_____ Marital Status:_____

Occupation:_____ Previous/Referring Physician:_____

PAST MEDICAL HISTORY

Do you have, or have you had in the past, any of the following conditions: (please circle)

Anxiety	Heart Disease	Osteoporosis	Tuberculosis
Asthma	Hepatitis	Rheumatoid Arthritis	STD
Depression	High Blood Pressure	Seizure Disorder	Diabetes
GERD	High Cholesterol	Stroke	Glaucoma
Heart Attack	Kidney Disease	Thyroid Disease	Anemia
Cancer – type_____		Anemia	Blood Clots
Migraine	Alcoholism	Other_____	

SURGICAL HISTORY

Please list any surgeries you have had with the dates performed:

_____ _____ _____

_____ _____ _____

CURRENT MEDICATIONS

Please list any prescription, over-the-counter, vitamins, and supplements including the dose:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES

Please list reactions that you have had to medications and what happened:_____

_____

Allergies to anything else?_____

HABITS

Cigarettes/Tobacco? Y N If yes, how much?_____ How long?_____ Type?_____

Alcohol? Y N If yes, how much?_____ How often?_____ Type?_____

Recreational or "Street drugs"(including marijuana, cocaine, meth, ecstasy, heroin)? Y N

If yes, what type?_____ How much?_____ How often?_____

PREVENTATIVE HEALTH

Tetanus shot? Y N If yes, when?_____ Flu shot? Y N If yes, when?_____

Pneumonia shot? Y N When?_____ Test for colon cancer? Y N When?_____

WOMEN: Date of last pap smear?_____ Normal? Y N Last mammogram?_____
Normal? Y N Date of last menstrual period?_____ Regular?___ Irregular?___

MEN: Date of last prostate exam?_____ Normal? Y N

FAMILY HISTORY

Relationship:	Living:	Age:	Significant Health Problems:
Mother	Y N	____	_____
Father	Y N	____	_____
Sibling	Y N	____	_____
Sibling	Y N	____	_____
Paternal Grandfather	Y N	____	_____
Paternal Grandmother	Y N	____	_____
Maternal Grandfather	Y N	____	_____
Maternal Grandmother	Y N	____	_____

Children Y N ____ _____

_____ Y N ____ _____

_____ Y N ____ _____

REVIEW OF SYSTEMS

Please circle any of these that apply to you or write in any that are not listed.

General:	Fever, chills, night sweats, fatigue, weakness, weight loss, sleep problems, poor concentration
Psychological:	Depression, anxiety, memory loss, phobias, confusion, anger_____
Eyes:	Blurred or double vision, dryness, pain, vision loss, wear glasses or contacts
Ears, Nose, Throat:	Pain, popping, ringing in ears, hearing loss, nasal congestion, nose bleeds, sore throat, hoarseness, snoring, excessive ear wax_____
Cardiovascular:	Chest pain, palpitations, light headedness, shortness of breath with walking, difficulty sleeping flat, heart disease, leg or ankle swelling_____
Respiratory:	Cough, shortness of breath at rest, excessive phlegm, bloody phlegm, wheezing, asthma
Gastrointestinal:	Nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, blood in stool, blood in vomit, gas, bloating, indigestion/heartburn, ulcers, hernia_____
For Men:	Painful or frequent urination, blood in urine, discharge from penis, testicle pain or swelling, difficulty achieving or maintaining erections, pain with ejaculation, history of STD's_____
For Women:	Vaginal discharge, painful urination, blood in urine, frequent urination, irregular/painful/heavy menses, pain/bleeding with intercourse, history of STD's
Muscles and Joints:	Back pain, joint pain, joint swelling, muscle cramps or pain, muscle weakness, arthritis, broken bones, dislocations, cold/blue fingers/toes___
Skin:	Rash, itching, dryness, moles, acne, flaky scalp, skin cancer_____
Neurological:	Numbness or tingling, seizures, tremors, dizziness, faintness, frequent falls, frequent headaches, difficulty walking, memory loss_____
Endocrine:	Cold or heat intolerance, excessive thirst, excessive urination, unusual weight change
Blood:	Abnormal bruising, abnormal bleeding, anemia, enlarged or swollen glands