Oregon City Family Practice Clinic, P.C.

Medical History

Name_____ DOB_____/_____/_____ Gender M F

Height: _____ Weight: _____

Current Medication List (Attach) or Medications & Dosages: _____

_____

_____

Do you have any Allergies to Medications (if yes, please list): _____

_____

List your current medical conditions: _____

_____

Surgical History (List type of surgery and date): _____

_____

Medical History-Please indicate with Yes or No, Circling the condition if marked Yes.

Head/Brain injuries, seizures, epilepsy, headaches, stroke or paralysis	Yes	No
Loss of or altered consciousness	Yes	No
Mental health/psychiatric disorders, depression or anxiety	Yes	No
Eye disorders or impairment, glaucoma, wear glasses, and double vision	Yes	No
Hearing Loss, hearing aids, ringing in ears, frequent ear infections	Yes	No
Heart disease or heart attack, murmur, high blood pressure, high cholesterol, thyroid problem	Yes	No
Shortness of breath, fainting or dizziness, loss of balance, numbness or tingling, swelling	Yes	No
Lung disease, emphysema, asthma, chronic bronchitis or TB	Yes	No
Kidney disease, kidney stones, dialysis, frequent urination/pain with urination or urinary tract infections	Yes	No
Diabetes or blood sugar problems, controlled by: ( ) diet ( ) medication ( ) insulin	Yes	No
Liver disease or hepatitis	Yes	No
Digestive problems, loss of appetite, trouble swallowing, heartburn, ulcers, bloating/belching	Yes	No
Frequent diarrhea/constipation, nausea/vomiting, blood in stools, gallbladder problems	Yes	No
Abdominal pain/hernia	Yes	No
Recent unexplained change in weight	Yes	No
Skin problems, eczema/psoriasis, bruising, mole change, rashes, itching	Yes	No
Skeletal/muscular problems, spine injuries, fractures, sprains, joint swelling	Yes	No
Sleep disorders, snoring, insomnia, daytime sleepiness, sleep apnea	Yes	No
FEMALE PATIENTS: problems with menstrual cycle, menopausal, hot flashes, mood changes	Yes	No

Social History

Do you exercise regularly? How often? _____	Yes	No
Do you smoke cigarettes or use smokeless tobacco? How much/often? _____	Yes	No
Do you drink alcohol beverages? How much/often? _____	Yes	No
Do you use other drugs? How much/often? _____	Yes	No
Have you ever had a problem with drugs or alcohol?	Yes	No

Family History

Please circle any of the following conditions experienced by your family. (Grandparents, parents, siblings)
Diabetes, Heart disease, Severe Anemia, Asthma, Emphysema, Bleeding Disorder, High blood pressure, Cancer, Arthritis, Nervous disorder, Peptic Ulcer Disease, Tuberculosis, Stroke, Kidney disease, Migraines, Epilepsy, Mental disorders

Pharmacy Name: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____