

**PATIENT MEDICAL HISTORY FORM**

<b>PATIENT NAME:</b> <input type="checkbox"/> M <input type="checkbox"/> F		<b>DO YOU HAVE OR HAVE YOU EVER HAD:</b> <i>(Circle those that apply and write in others)</i>
<b>DATE OF BIRTH:</b> <b>AGE:</b> <b>HEIGHT:</b> <b>WEIGHT:</b>	<b>Have you ever been diagnosed with or exposed to a MRSA infection?</b>	
<b>PRIMARY CARE DOCTOR &amp; TELEPHONE #:</b>		<b>Do you have a personal/family history of DVT (Blood clots)?</b>
<b>OCCUPATION:</b>		<b>Eye, ear, nose, throat problems:</b> (glaucoma: lens implants; dentures; difficulty hearing; wear hearing aids, glasses or contacts)
<b>EMPLOYER:</b>		<b>Heart problems:</b> (chest pain, angina, heart attack, congestive heart failure, irregular heart beats, pacemaker)
<b>LIST BODY PART TO BE SEEN:</b>		<b>Vascular problems:</b> (high blood pressure, blood clots)
<b>INJURIES:</b> (Indicated if on-the-job or MVA)		<b>Lung Problems:</b> (asthma, emphysema, tuberculosis, coughing, coughing blood, abnormal chest x-ray, sleep apnea)
<b>DATE OF INJURY:</b>		<b>Gastrointestinal problems:</b> (hepatitis, cirrhosis, ulcers, reflux, hiatal hernia, intestinal bleeding, heartburn)
<b>TREATMENT BEFORE ARRIVAL?</b>		<b>Genitourinary problems:</b> (OB/GYN, kidney disease/failure, prostate problems, incontinence, sexually transmitted diseases, infections)
<b>ALLERGIES TO MEDICINE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:      (known reaction)		<b>Is there any possibility you could be pregnant?</b>
<b>MEDICATION</b> <input type="checkbox"/> NONE <b>DOSE/FREQUENCY</b>		<b>Musculoskeletal problems:</b> (back problems, broken bones, gout, limited range of motion, arthritis, TMJ)
		<b>Skin problems:</b> (rash, hives, bruise easily, open sores)
		<b>Neurological problems:</b> (seizures, paralysis/numb areas, stroke, weakness, migraines, confusion, dizziness)
		<b>Psychiatric Care:</b> (anxiety, depression, bipolar disorder)
		<b>Endocrine problems:</b> (diabetes, thyroid, weight gain/loss) If diabetic, controlled by:    diet    oral agent    insulin
		<b>Blood Disorders:</b> Anemia / Unusual bleeding problems / HIV/High Cholesterol
<b>DO YOU USE:</b> <b>ASPIRIN</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>TOBACCO</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    PPD ____    QUIT? <b>ALCOHOL</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    GL/DAY ____    GL/WK ____ <b>RECREATIONAL DRUGS:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:		<b>Cancer:</b>
		<b>A bad reaction to anesthesia?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
		<b>Hobbies</b>
<b>SURGERIES, HOSPITALIZATIONS, BIRTHS OR ILLNESSES:</b> (Include Dates)		<hr/> <b>PATIENT SIGNATURE</b> <b>DATE</b>
<b>FAMILY HISTORY:</b> (Cancer, Stroke, Heart Disease)		

**How did you hear about us?**     Primary Care Physician Referral     Emergency Room Referral     Chamber of Commerce  
 School Referral     Website     The Split Restaurant     KATU     Friend Referral     Oregon City Golf Course  
 Other

**HISTORY REVIEWED:** \_\_\_\_\_  
 DATE      INITIALS      DATE      PHYSICIAN SIGNATURE