Central Oregon Family Medicine
Health History Questionnaire

Patient Name:_____Date of Birth:_____
Reason for visit: _____

Past Medical History: (check all that apply)

☐Anxiety
☐Depression
☐Bipolar Disorder
☐Insomnia
☐Anemia
☐Bleeding Disorder
☐Blood Clots (PE or DVT)
☐Eczema
☐Psoriasis
☐Seasonal Allergies
☐Cancer – specify type
_____
☐Asthma
☐COPD/emphysema
☐Sleep Apnea
☐Heart Failure
☐Coronary Artery Disease
☐Heart Attack
☐Atrial Fibrillation
☐Pacemaker
☐High Blood Pressure
☐High Cholesterol
☐Heart Murmur
☐Leg/Foot Ulcers
☐Diabetes
☐Colon polyps
☐Diverticulosis/Diverticulitis
☐Stomach Ulcers
☐GI Bleeding
☐Crohn's Disease
☐Ulcerative Colitis
☐Autoimmune Disorder
☐Chronic Back Pain
☐Osteoarthritis
☐Rheumatoid Arthritis
☐Gout
☐Overactive Thyroid
☐Underactive Thyroid
☐Stroke
☐Memory Loss/Dementia
☐Parkinson's Disease
☐Seizure Disorder
☐Migraine Headache
☐Restless Leg Syndrome
☐Kidney Disease
☐Kidney Stones
☐Tuberculosis
☐Hepatitis
☐HIV/AIDS
☐Glaucoma
☐Macular Degeneration

Gynecological History:
Last Menstrual Period: _____ # of Pregnancies: _____ # of Births: _____ # of C-sections: _____
History of hormone replacement therapy (dates): _____

Past Surgical History:

Surgery	Reason	Date/Location
1.		
2.		
3.		
4.		
5.		

Medications: (list all prescription and over the counter medication, supplements, CPAP and oxygen)

Medication	Strength/Dose	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Medication Allergies:

Medication	Reaction
1.	
2.	
3.	

Health Maintenance:

☐Colonoscopy Date: _____ Provider/Location:_____
☐Eye Examination Date: _____ Provider/Location:_____
☐Bone Density Date: _____ Provider/Location:_____
☐Mammogram Date: _____ Provider/Location:_____
☐Pap Smear Date: _____ Provider/Location:_____

Immunizations:

☐Gardasil/HPV #1	Date: ______________	☐Meningococcus	Date: _____________
☐Gardasil/HPV #2	Date: ______________	☐MMR (measles, mumps, rubella)	Date: _____________
☐Gardasil/HPV #3	Date: ______________	☐Pneumonia	Date: _____________
☐Hepatitis A #1	Date: ______________	☐Tdap (tetanus and pertussis)	Date: _____________
☐Hepatitis A #2	Date: ______________	☐Tetanus	Date: _____________
☐Hepatitis B #1	Date: ______________	☐Flu Shot	Date: _____________
☐Hepatitis B #2	Date: ______________	☐Zostavax/Shingles	Date: _____________
☐Hepatitis B #3	Date: ______________		

Family History:

Relation	Alive	Age	Significant Health Problems		
Father	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ________________	☐Cancer ☐Diabetes ☐Osteoporosis
Mother	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ________________	☐Cancer ☐Diabetes ☐Osteoporosis
Sibling	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ________________	☐Cancer ☐Diabetes ☐Osteoporosis
Sibling	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ________________	☐Cancer ☐Diabetes ☐Osteoporosis
Sibling	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ________________	☐Cancer ☐Diabetes ☐Osteoporosis
Child	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ________________	☐Cancer ☐Diabetes ☐Osteoporosis
Child	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ________________	☐Cancer ☐Diabetes ☐Osteoporosis

Other Family History (grandparents, extended family):

Social History:

Education (highest level): __________

Occupation: ___________________

Marital Status
☐Single ☐Married ☐Partner
☐Widowed ☐Divorced

Exercise:
Type: _______________________
Frequency: ___________________

Tobacco
Do you use tobacco?
☐Yes ☐No ☐Past
How many packs per day? _____
How many cans per day? _____
How many years of use? _____
Year quit: _____

Drugs
Do you use recreational or street drugs?
☐Yes ☐No ☐Past

Alcohol
Do you use alcohol?
☐Yes ☐No
How many drinks per week? ___
Have you ever been treated for alcoholism?
☐Yes ☐No

Review of Systems: (check all symptoms you are concerned about that have occurred in the last 1 month)

Constitutional
☐Fatigue
☐Fever
☐Night Sweats
☐Weight Change
☐Decreased Appetite

Eyes
☐Dry Eyes
☐Vision Change

Ears/Nose/Mouth/Throat
☐Bleeding Gums
☐Dry Mouth
☐Mouth Ulcers
☐Hearing Loss
☐Ear Pain
☐Ringing in Ears
☐Frequent Nosebleeds
☐Runny Nose
☐Sinus Pressure
☐Hoarseness

Respiratory
☐Cough
☐Coughing Up Blood
☐Shortness of Breath
☐Wheezing

Cardiovascular
☐Chest Pain/Pressure
☐Irregular Heartbeats
☐Swelling/Edema
☐Shortness of Breath with Lying Down
☐Shortness of Breath with Exertion
☐Awakening Short of Breath

Genitourinary
☐Abnormal Vaginal Bleeding
☐Painful Urination
☐Incomplete Bladder Emptying
☐Urinary Frequency
☐Urinary Loss of Control

Gastrointestinal
☐Abdominal Pain
☐Nausea/Vomiting
☐Diarrhea
☐Constipation
☐Vomiting Blood
☐Black or Bloody Stool
☐Heartburn
☐Difficulty Swallowing
☐Hemorrhoids

Skin
☐Changes in Moles
☐Growth/Lesion
☐Rash
☐Itching
☐Yellowing of Skin

Musculoskeletal
☐Back Pain
☐Joint Pain
☐Muscle Aches
☐Muscle Weakness

Neurologic
☐Dizziness
☐Vertigo
☐Fainting
☐Seizure
☐Numbness/Tingling
☐Restless Legs
☐Weakness
☐Headaches

Endocrine
☐Increased Thirst
☐Intolerance to Heat
☐Intolerance to Cold

Psychiatric
☐Depression
☐Anxiety
☐Mania
☐Difficulty Sleeping

Hematologic/Lymphatic
☐Easy Bleeding/Bruising
☐Swollen Glands

Other Providers: (include all specialists and other health providers)

Provider Name	Specialty
1.	
2.	
3.	

Durable Medical Equipment: (include names of companies providing medical equipment and supplies)

Company Name	Supplies
1.	
2.	

Other Health History:

Patient Signature: _____ Date: _____

Revised 3/06/15