PERSONAL MEDICAL HISTORY

Name____________________________________Date of birth________________Today's date________________

Curent medical problems you get or need treatment for: ☐ I have no medical problems, just here for a checkup

____

____

____

____

____

____

____

____

____

ALLERGIES to medicine/ dye/ tape, foods, etc:	**REACTION** (what happened when you were exposed to it?)
____	____
____	____
____	____
____	____

☐ I have no allergies to medicines, dyes, tape, or foods

Have you ever been in the hospital (overnight, not emergency room)?

Please give approximate dates, location of hospital, reason you were there, and outcome:

These issues sometimes run in families. Did you or any close family members ever have these? Who?

☐ High blood pressure ___________________________

☐ High cholesterol ______________________________

☐ Asthma ___________________________________

☐ Thyroid problem ______________________________

☐ Diabetes __________________________________

☐ Blood clot in leg or lung _______________________

☐ Heart attack/ heart failure ______________________

☐ Stroke/ mini-stroke (TIA) _______________________

☐ Breast cancer _______________________________

☐ Cancer of ovary _____________________________

☐ Colon cancer ________________________________

☐ Prostate cancer ______________________________

☐ Depression _________________________________

☐ Osteoporosis _______________________________

☐ Other______________________________________

____

See next page for complete family history form. Please DISREGARD if you are adopted!

Family History: For each person or group (blood relatives only), fill in any medical problem they had, and how old they were when they first had it. *Examples: Diabetes (age 12), Breast cancer (75), Fibromyalgia (in 40s), Heart attack (in 50s), Thyroid surgery (35), Alcoholism (25), Drugs (since teen), Depression (age 20), Alzheimer's (80), etc.*

MY MOTHER

Problem	Age

Mom's mother:

Problem	Age

Mom's father:

Problem	Age

Mom's sisters/brothers:

Problem	Age

MY SISTERS How many ___________

Problem	Age

MY BROTHERS How many __________

Problem	Age

My cousins: How many _____________

Problem	Age

MY FATHER

Problem	Age

Dad's mother:

Problem	Age

Dad's father:

Problem	Age

Dad;s sisters/brothers:

Problem	Age

MY KIDS How many ______________

Problem	Age

Kids of my sisters/brothers: How many ____________

Problem	Age

Other concerns about inherited conditions:_____________
____
____
____

FOR WOMEN (biological female) ONLY:

Age menstruation started________ Age menopause started________ Date of last menstrual period________________

Number of times you have ever gotten pregnant in your whole life______ Number of living children now, if any_______

Number of times you have ever given birth________ How old were you the first time you gave birth?______________

Ever nursed a child at the breast? ☐ No ☐ Yes, total number of years or months:______________________________

Ever have a breast biopsy? ☐ No ☐ Yes, year and result:____

Had a hysterectomy? ☐ No ☐ Yes, for heavy bleeding ☐ Yes, other reason:__________________________________

If you had a hysterectomy, do you still have your cervix? ________ Do you still have one or both ovaries?__________

Any current problems with menstrual cycles or menopause:____

Any current sexual problems:____

If heterosexually active, how do you prevent pregnancy?____

How do you prevent sexually transmitted infections?____

Have you had any of the following risk factors for blood-borne viruses (HIV, hepatitis C, etc.):

☐ Ever used IV drugs? ☐ Had a sexual partner (even short-term) who used them?

☐ Ever got blood transfusions? ☐ Had a sexual partner(even short-term) who did?

☐ Ever been in prison? ☐ Had a sexual partner(even short-term) who has been in prison?

FOR MEN (biological male) ONLY:

Number of times you've ever gotten someone pregnant, if any________ Number of living children now, if any________

Any current concerns about fertility:____

Any current concerns about sex:____

If heterosexually active, how do you prevent pregnancy?____

How do you prevent sexually transmitted infections?____

Have you had any of the following risk factors for blood-borne viruses:

☐ Ever used IV drugs? ☐ Had a sexual partner (even short-term) who used them?

☐ Ever got blood transfusions? ☐ Had a sexual (even short-term) partner who did?

☐ Ever been in prison? ☐ Had a sexual partner (even short-term) who has been in prison?

FOR EVERYONE: ***Check which recent tests you have had:***

☐ Pap test (women, age 21+) Year________ Ever abnormal?_______ Treatment:_______________________________

☐ Chlamydia/gonorrhea test (women, 16-25) Year________ Ever abnormal?_______ Partner treated?______________

☐ Mammogram (women, 50+) Year________ Ever abnormal?_______ Treatment:_______________________________

☐ Bone density test (age 65+) Year________ Ever abnormal?_______ Treatment:_______________________________

☐ Prostate exam/ PSA test (men, 40-50) Year_______ Ever abnormal?______ Treatment:_______________________

☐ Cholesterol test (everyone, 35+) Year______ Ever abnormal?______ Treatment:_____________________________

☐ Diabetes test (age 45+) Year________ ☐ normal ☐ "pre-diabetes", year________ ☐ diabetes, year_____________

☐ Colon cancer screening (50+) Year______ Ever abnormal?______ Treatment:_________________________________

When was your last...

Tetanus shot? (year) ________________________________

Flu shot? (year) ____________________________________

HIV test? (year) ____________________________________

Have you had a pneumonia shot? ☐ Yes ☐ No

Chicken pox: ☐ I had the chicken pox or the shot

☐ I never had the chicken pox or the shot

Dentist visit? (year) _____________________________

Eye exam? (year) _______________________________

Social History. These answers, which are strictly confidential, have an impact on your health:

Where did you grow up?____

How far did you go in school?______________________ If degree, in what field?__________________

Do or did you work at a job? If so, what job?______________________________________

If not, how long have you been out of work?______________________ ☐ On disability since (year) ________

Do you currently have legal problems? What kind?______________________________________

Who lives at home with you?____

Do you have any pets? What pets?____

Who is your biggest source of emotional support (who is really "there for you")?________________________

Is there anyone in your life who fights with you a lot? How do you handle it?__________________________

____

Do you have a regular spiritual practice? If so, what is it?______________________________________

Diet:

How many full meals do you usually eat in 24 hrs?_______How many snacks do you usually have in 24 hrs?________

Do you:

☐ Eat breakfast? How often____________________

☐ Eat meat/poultry? How often__________________

☐ Eat fish? How often_________________________

☐ Eat/drink dairy? How often___________________

☐ Eat fast food? How often_____________________

☐ Eat at a restaurant? How often_________________

☐ Drink juice/eat fruit? How often_________________

☐ Drink soda pop? How much daily________________

☐ Coffee/caffeine? How much daily________________

☐ Beer/wine/alcohol? How much daily______________

☐ Eat chips/salty snack? How often________________

☐ Eat sweet treat/dessert? How often______________

Favorite foods:____

Foods you avoid, and why:____

Exercise:

Do you have a formal exercise program? If so, what is it?____________________________________

How many city blocks can you walk without stopping:____________________________ ☐ never any limit

How many flights of stairs can you climb without stopping:_________________________ ☐ never any limit

How many bags of groceries can you carry at one time:__________________________ ☐ never any limit

Favorite kind of exercise:____

Any limitations on exercise? What are they?____

Safety:

How many packs of cigarettes do you smoke in a week?_________Do you live with a smoker?_______________

Do you use recreational drugs? If so, what ones?____

Have you ever been in a recovery program to become clean or sober? Year/s:________________________

When you drive, do you wear a seatbelt? ☐ sometimes ☐ always ☐ not usually ☐ it depends

When you ride a bike or motorcycle, do you wear a helmet? ☐ sometimes ☐ always ☐ don't own one

Does your home have smoke detectors? ☐ yes ☐ no ☐ don't know When did you last replace batteries? ________

Do you own any guns?☐ yes ☐ no How many?________ How are they stored?________________________

Do you have safety concerns about your family, school, workplace, home, neighborhood, etc.? ________________

____

Current health issues

What health and fitness providers do you see regularly?

☐ Naturopath/homeopath. How often:________________
☐ Chiropractor. How often:__________________________
☐ Physical therapist. How often:_____________________
☐ Massage therapist. How often:_____________________
☐ Energy worker. How often:________________________
☐ Personal trainer/coach. How often:_________________
☐ Counselor/therapist. How often:___________________
☐ Dentist/orthodontist. How often:___________________
☐ Medical/surgical specialists: ______________________
____
☐ Other:_______________________________________
____

Please check off whether these are <u>current problems you need help with</u>:

Head, eyes, ears, nose, and throat:
(☐ not current problems for me)
☐ Headaches
☐ Vision
☐ Eye pain
☐ Eyelid problems
☐ Ear pain
☐ Noise in ears
☐ Hearing loss
☐ Voice problems
☐ Chewing or swallowing

Heart, lungs, blood vessels:
(☐ not current problems for me)
☐ Hard to breathe, short of breath
☐ Cough and/or wheeze
☐ Chest pain or pressure
☐ Heart pounding/ fluttering/ palpitations
☐ Fainting, or near-fainting
☐ Leg pain while walking
☐ Restless/cramping legs at rest
☐ Leg, foot, ankle swelling

Belly:
(☐ not current problems for me)
☐ Heartburn/reflux
☐ Burping, gas
☐ Disordered eating/body image
☐ Nausea, loss of appetite
☐ Belly pain
☐ Rectal pain
☐ Loose or liquid stools
☐ Hard and painful stools
☐ Bloody bowel movements

Urinary and genital area:
(☐ not current problems for me)
☐ Frequent or urgent need to pee
☐ Red, dark, painful or bad-smelling pee
☐ Accidentally leaking pee
☐ Difficulty starting to pee, dribbling or weak stream
☐ Difficulty getting sexually aroused
☐ Difficulty maintaining an erection
☐ Pain during sex, during penetration, or during erection
☐ Feeling upset, scared, or angry about sex
☐ Vaginal dryness
☐ Unusual discharge from your genitals
☐ Itching or burning of genitals
☐ Birth control issues

Breast:
(☐ not current problems for me)
☐ Lump
☐ Pain
☐ Discharge from nipple
☐ Uneven size or shape

Skin, nails, hair:
(☐ not current problems for me)
☐ Skin rash or lesion
☐ Lump
☐ Slow healing wound/ulcer
☐ Concern about a mole
☐ Acne
☐ Fingernail/toenail problem
☐ Hair falling out
☐ Scalp problem

Bones, muscles, nerves:
(☐ not current problems for me)
☐ Back pain
☐ Neck pain
☐ Pain in joint/s
☐ Red, puffy, or stiff joints
☐ Pain and fatigue all over the body, with flareups
☐ Fingers go numb, change color when cold
☐ Weak muscles that tire quickly
☐ I have gout, or I have rheumatoid arthritis
☐ I have a connective tissue disease (lupus, etc)
☐ Numbness, pins and needles
☐ Vertigo (like the room is spinning)
☐ Dizziness (like you'll lose your balance)
☐ Falling down
☐ Seizures or repeated concussions

Psyche:
(☐ not current problems for me)
☐ Can't sleep
☐ Not enjoying life anymore
☐ Feeling guilty or hopeless
☐ Grieving someone or something
☐ Persistent thoughts of death
☐ Mood swings that others comment on
☐ Fighting with loved ones
☐ Feeling irritable, angry
☐ Hearing voices or getting messages
☐ Can't stop worrying
☐ Panic attacks or flashbacks
☐ Losing your memory

Medications:

Please list all medications, birth control, vitamins, homeopathics, herbs, and natural supplements you currently take. (Over-the-counter medicines are listed at the bottom of this page.)

Name of medicine or supplement	Approx. year you started it	Who prescribed or recommended it?	Dosage (mg, droppers, etc.)	How or how often (with meals, every 4 hours, at bedtime, as needed, etc.)	What's it for?

Do you use any of these over-the-counter medications more than once a week? ☐ No ☐ Yes:

☐ Pain relievers:________________________________ ☐ Laxatives:__________________________________

☐ Allergy remedies:______________________________ ☐ Other:_____________________________________

☐ Stomach medicines:____________________________ ____

Do you use oxygen? ☐ No ☐ Yes Since what year ____________ How many liters at this time ______________

Do you currently use marijuana for medical purposes? ☐ Yes ☐ No

If yes, do you have a current card for the Oregon Medical Marijuana Program (OMMP)? ☐ Yes ☐ No

If you are in the OMMP, what is your qualifying health condition? ________________________________

Other health concerns you would like to mention:

That's all! Thank you for filling out this CONFIDENTIAL medical history.