**Oregon City Family Practice Clinic, P. C.**

Medical History

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Gender: M F Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List all Current Medications (Attach) or Medications & Dosages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**List any Allergies to Medications (If none write “none”): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**List any Current Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**List any Surgical History (Type of surgery and date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**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, 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, or insulin Yes No

Liver disease or hepatitis Yes No

Digestive problems, loss of appetite, trouble swallowing, heartburn, 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 change 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 alcoholic 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

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: \_\_\_\_\_\_\_\_\_**