Physicians' Building Group Medical History Form

1234 Commercial St SE
Salem OR 97302
(503) 362-9334

Name_____ Date of Birth_____ Date ___/___/___
Last First Middle (mm/dd/yyyy)

Reason for today's visit: _____

Have you ever had any of the following?

	NO	YES	If yes, describe and list dates
1. Diabetes	☐	☐	_____
2. High Blood Pressure	☐	☐	_____
3. Stroke	☐	☐	_____
4. Heart Attack	☐	☐	_____
5. Congestive Heart Failure	☐	☐	_____
6. Abnormal Heart Rhythm	☐	☐	_____
7. Heart Murmur	☐	☐	_____
8. Cancer	☐	☐	_____
9. Emphysema/COPD	☐	☐	_____
10. Asthma	☐	☐	_____
11. Tuberculosis/+ PPD	☐	☐	_____
12. Abnormal Chest X-ray	☐	☐	_____
13. Ulcers	☐	☐	_____
14. High Cholesterol	☐	☐	_____
15. Arthritis	☐	☐	_____
16. Anesthesia Complications	☐	☐	_____
17. Anxiety, Depression or Mental illness?	☐	☐	_____
18. Thyroid Diseases	☐	☐	_____
19. Sleep Apnea	☐	☐	_____
20. Surgery	☐	☐	_____ _____
21. Surgery (cont'd)	☐	☐	_____ _____
22. Surgery (cont'd)	☐	☐	_____ _____

List any allergies to medications: _____ Medication/Item_____Describe Reaction_____

_____
_____
_____
_____

Medications: (list any/all medications currently taking, including vitamins, herbal supplements, over the counter medications and narcotics)		
Name	**Strength**	**Directions**

Place of birth_____ Occupation_____
Level of Education_____ Marital Status_____
Previously Divorced? _____ Previously Widowed? _____
Children? _____ # Sons_____ # Daughters_____
Who lives with you currently? _____
Hand Dominance _____Right _____Left
Do you have military experience? _____

Social History			
	Yes	**No**	**Answers**
Do you smoke or chew tobacco?			No. packs/day:
Have you ever smoked in the past?			Date started: Date stopped:
Ever had a drinking problem?			
Do you drink caffeine?			What type: No per/day:
Do you drink alcohol?			How often: Type:
Do you use illegal drugs?			What type:
Do you exercise regularly?			Times/week:
What type of exercise?			Length:
Hobbies/Activities?			What type?
Are you sexually active?			No. Partners:

Men Only:

Do you do self-testicular exams? _____ Birth control method? _____

Any?

- ☐ Discharge from Penis
- ☐ Risk factors for AIDS
- ☐ Stream weak or slow
- ☐ Other
- ☐ Prostate problem
- ☐ Sexual Difficulty

Women Only:

Age menstruation started _____ # pregnancies _____ # Miscarriages _____

Period every _____ days Birth control method _____

Flow last _____ days Do you do self breast exams? _____

Date of last menses _____ Date last mammogram _____ Date last pap _____

Menopausal? _____ Age? _____

Any?

- ☐ Abnormal pap smears
- ☐ Vaginal discharge
- ☐ Hot flashes
- ☐ Infertility problems
- ☐ Sexual Difficulty
- ☐ Risk factors for AIDS

Any menstrual problems?

- ☐ Heavy periods
- ☐ Infrequent
- ☐ Irregular
- ☐ Painful
- ☐ Spotting
- ☐ Other

Immunizations/Screening	Yes	No	Year	Reaction?
Pneumonvax				
Tetanus				
Shingles				
Flu				
Hepatitis B				
Tb Test?				
Flex Sig or Colonoscopy				
Last Eye Exam				

Family History: Please indicate if any of the following family members have had the following and at what age if it resulted in the cause of death:
(Mother, father, brother, sister, grandfather, grandmother, aunt, or uncle)

Have any of the following blood relatives had: (mother, father, grandparent, brother, sister)					
	Yes	**No**	**Who**	**Year**	**Cause of Death?**
Alcoholism					
Allergies					
Asthma					
Anxiety, Depression, or Mental Illness					
Arthritis					
Cancer (please specify)					
Diabetes					
Emphysema/COPD					
Glaucoma					
Heart Attack					
Heart Trouble					
High Blood Pressure					
High Cholesterol					
Osteoporosis					
Psychiatric Illness					
Stroke					
Tuberculosis					
Ulcers					
Weight Problems					

List names of previous Physicians/Specialists:

_____
_____
_____
_____