Patient History Questionnaire

Today's Date: _____

Name of Patient: _____

Parent(s) name for minor: _____

Sex: ☐ Male ☐ Female **Date of Birth:** _____

Home Phone Number: _____ **Work Phone Number:** _____

Email: _____

Name of Insurance Company: _____

I have a living Will/Advance Directive ☐ Yes ☐ No **Religious Preference:** _____

Allergies: (☐ None)

Date	Drug	Reaction

Current Medications: (☐ None)

Name of Medication	Dose	How Often?	Name of Medication	Dose	How Often?

Pharmacy used: _____

Medical History: (☐ None)

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Blood Transfusion
☐ Cancer
☐ Cataracts
☐ CHF
☐ Clotting Disorder
☐ COPD
☐ Depression
☐ Diabetes
☐ Emphysema
☐ GERD
☐ Glaucoma
☐ Valvular Problems/Murmurs
☐ HIV
☐ Hypertension
☐ Kidney Trouble
☐ Meningitis
☐ MI
☐ Nerve/Muscle Disease
☐ Osteoporosis
☐ Seizures
☐ Sickle Cell Anemia
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcer
☐ Other: _____

PATIENT LABEL

Willamette Health Partners
A part of Salem Health

Clinic: _____

PATIENT HISTORY QUESTIONNAIRE

Surgical History: (☐ None)

☐ Appendectomy ☐ C-Section ☐ Prostate surgery
☐ Brain surgery ☐ Eye surgey ☐ Small intestine surgery
☐ Breast surgery ☐ Fracture surgery ☐ Spine surgery
☐ CABG ☐ Hernia repair ☐ Tubal Ligation
☐ Cholecystectomy ☐ Hysterectomy ☐ Valve replacement
☐ Colon surgery ☐ Joint replacement ☐ Vasectomy
☐ Cosmetic surgery
☐ Other: _____

Social History:

Tobacco Use? _____ Type(s) used ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarette ☐ Nicotine Replacement

Packs/day ☐ 0.25 ☐ 0.50 ☐ 1 ☐ 1.5 _____

Years: ☐ 0.5 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 10 ☐ 15 _____

Smokeless Tobacco: _____ Type(s) used ☐ Snuff ☐ Chew

Quit date: _____ Ready to Quit: ☐ Yes ☐ No

Alcohol Use? ☐ Yes ☐ No Comments: _____

How many Drinks do you have a week? _____ Glasses of Wine _____ Cans of beer _____ Shots of liquor

Drug Use? ☐ Yes ☐ No Comments: _____

How often do you use drugs a week? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 _____

What type of drugs do you use? ☐ IV ☐ Methamphetamine ☐ Amphetamines ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ PCP ☐ Mushrooms ☐ Skin popping ☐ Smoking ☐ Snorting ☐ Huffing ☐ Oral

Other: _____

Sexual activity? ☐ Yes ☐ No ☐ Not Currently Comments: _____

Birth Control/Protection ☐ Condom ☐ Pill ☐ Diaphragm ☐ IUD ☐ Surgical ☐ Spermicide ☐ Implant ☐ Rhythm ☐ Injection ☐ Sponge ☐ Inserts ☐ Abstinenece

Family History: (☐ None)

Relationship	Name	Status	Alcohol/Drug	Arthritis	Asthma	Birth defects	Cancer	COPD	Depression	Diabetes	Early death	Hearing loss	Heart disease	Hyperlipidemia	Hypertension	Kidney/Urinary	Learning disability	Mental illness	Mental retardation	Miscarriages	Stroke	Vision Loss
Fa																						
Mo																						
MGMo																						
MGFa																						
PGMo																						
PGFa																						
OTHER																						

KEY: Fa= Father Mo= Mother MGMo= Maternal Grandmother MGFa=Maternal Grandfather
PGmo= Paternal Grandmother PGFa= Paternal Grandfather