Maple Street Clinic, P.C.

FAMILY MEDICINE
1825 Maple Street
Forest Grove, OR 97116
Phone (503) 357-2136 Fax (503) 359-5479

HEALTH HISTORY

Patient Name	Sex ☐M ☐ F	Birthdate	Date

SOCIAL HISTORY
Tobacco ☐Current Type: Frequency: ☐2nd hand ☐No ☐ Prior use Quit date:
Alcohol ☐ No ☐ Occasional ☐ Daily History of alcohol use: (describe)
Caffeine ☐ No ☐ Occasional ☐ Daily
Other Drugs ☐ No ☐ Occasional ☐ Daily ☐ Prior use Quit date: History of drug use: (describe) Types:
Occupation
Home environment ☐ Private home ☐ Assisted living ☐ Other: (describe)

OTHER PHYSICIANS AND PROVIDERS OF CARE			
Name of Provider	Specialty/provider type	Type of care	Date discontinued

FAMILY HISTORY use ✓ to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart disease									
Stroke									
Diabetes									
Kidney disease									
Obesity									
Genetic disorder									
Alcoholism									
Liver disease									
Depression									
Colon or rectal cancer									
Breast cancer									
Other cancer:_____									
Other: _____									

7/23/12

_____

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HEALTH HISTORY

PERSONAL MEDICAL HISTORY

Please mark any condition you have ever had

☐ Measles	☐ Migraine headaches	☐ Hives or eczema
☐ Tuberculosis	☐ Mononucleosis	☐ Chicken Pox
☐ Bronchitis	☐ Cancer	☐ Heart valve problem
☐ Polio	☐ Stroke	☐ Glaucoma
☐ Smallpox	☐ Hernia	☐ Ulcer
☐ Kidney disease	☐ Rheumatic fever	☐ Thyroid disease
☐ Back trouble	☐ Bleeding tendency	☐ Arthritis
☐ Anemia	☐ Epilepsy	☐ Bladder infections
☐ Venereal disease	☐ High blood pressure	☐ Blood transfusions
☐ Mumps	☐ Diabetes	☐ Scarlet fever
☐ Hepatitis	☐ Pneumonia	☐ Heart disease
☐ Asthma	☐ Hemorrhoids	☐ Whooping cough

Please list any other disease or condition, including serious accidents, injuries, fractures/broken bones, etc.

Date of last menstrual period	No of pregnancies	No of births

Hospital/Emergency Room visits since last office visit

Reason for hospital visit	Facility	Attending Physician	Date of hospital visit

Past surgeries

Surgery	Date	Complications	Surgeon/Hospital

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HEALTH HISTORY

Do you have trouble hearing the television or radio when others do not?	☐ Yes ☐ No
Do you have to strain or struggle to hear/understand conversations?	☐ Yes ☐ No
Do you have a regular exercise program?	☐ Yes ☐ No
Would you like to discuss or participate in a physical fitness program?	☐ Yes ☐ No
Over the past two weeks, have you felt down, depressed or hopeless?	☐ Yes ☐ No
Over the past two weeks, have you felt little interest or pleasure in doing things?	☐ Yes ☐ No
Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? (Circle positive answers)	☐ Yes ☐ No
Does your home have: Rugs in the hallway? ☐ Yes ☐ No Grab bars in the bathroom? ☐ Yes ☐ No Poor lighting? ☐ Yes ☐ No Handrails on the stairs? ☐ Yes ☐ No	
Are you having difficulties driving your car?	☐ Yes ☐ No
Do you always fasten your seat belt when you are in a car?	☐ Yes ☐ No
Do you have problems with balance or have you fallen two or more times in the past year?	☐ Yes ☐ No
Do you have trouble taking medicines the way you have been told to take them?	☐ Yes ☐ No

List other health concerns you would like your provider to discuss with you:

7/23/12

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