

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 <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Date
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SOCIAL HISTORY

Tobacco <input type="checkbox"/> Current Type: _____ Frequency: _____ <input type="checkbox"/> 2nd hand <input type="checkbox"/> No <input type="checkbox"/> Prior use Quit date: _____
Alcohol <input type="checkbox"/> No <input type="checkbox"/> Occasional <input type="checkbox"/> Daily History of alcohol use: (describe) _____
Caffeine <input type="checkbox"/> No <input type="checkbox"/> Occasional <input type="checkbox"/> Daily
Other Drugs <input type="checkbox"/> No <input type="checkbox"/> Occasional <input type="checkbox"/> Daily <input type="checkbox"/> Prior use Quit date: _____ History of drug use: (describe) _____ Types: _____
Occupation _____
Home environment <input type="checkbox"/> Private home <input type="checkbox"/> Assisted living <input type="checkbox"/> 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: _____									

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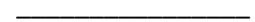
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HEALTH HISTORY

PERSONAL MEDICAL HISTORY			
Please mark any condition you have ever had			
<input type="checkbox"/> Measles	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Hives or eczema	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Chicken Pox	
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart valve problem	
<input type="checkbox"/> Polio	<input type="checkbox"/> Stroke	<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Smallpox	<input type="checkbox"/> Hernia	<input type="checkbox"/> Ulcer	
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Back trouble	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Bladder infections	
<input type="checkbox"/> Venereal disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Blood transfusions	
<input type="checkbox"/> Mumps	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Scarlet fever	
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Heart disease	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> 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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Do you have trouble hearing the television or radio when others do not?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have to strain or struggle to hear/understand conversations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a regular exercise program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to discuss or participate in a physical fitness program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Over the past two weeks, have you felt down, depressed or hopeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Over the past two weeks, have you felt little interest or pleasure in doing things?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? (Circle positive answers)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your home have: Rugs in the hallway? <input type="checkbox"/> Yes <input type="checkbox"/> No Poor lighting? <input type="checkbox"/> Yes <input type="checkbox"/> No	Grab bars in the bathroom? <input type="checkbox"/> Yes <input type="checkbox"/> No Handrails on the stairs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you having difficulties driving your car?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you always fasten your seat belt when you are in a car?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have problems with balance or have you fallen two or more times in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble taking medicines the way you have been told to take them?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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