Deschutes Family Care **Patient History**

Name _____ **Date of Birth** _____

Date _____ **Gender** _____

Medical Diagnoses/Problem List:

□ Asthma □ High blood pressure
□ Stroke/TIA □ High cholesterol
□ ADHD □ GERD/acid reflux
□ Diabetes □ Glaucoma
□ IBS □ Kidney problems
□ Arthritis □ Ulcers
□ Thyroid problems □ Autoimmune dx
□ Seasonal allergies □ Heart disease/CHF
□ Liver disease □ Cataracts
□ COPD □ Bipolar disorder
Other:_____
_____

BP___ HR__ RR__ 02__ Wt___ Ht___ T___
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Tobacco: □ Never □ Quit (date)_____
□ Cigarettes(pack/day)_____ □ Other_____
Duration (years) _____

Surgical history/Major events:
_____
_____
_____
_____

Family History:

□ Heart disease/MI/CHF □ Kidney problems □ Suicide
□ Cancer □ Autoimmune dx □ Schizophrenia
□ Stroke/TIA □ Blood clots □ Seizure disorder
□ High blood pressure □ Bipolar disorder □ Genetic disorder
□ Diabetes □ Drug/alcohol abuse □ Other: _____
_____

Health Maintenance:

Self reported health: □ *Excellent* □ *Great* □ *Good* □ *Fair* □ *Poor* □ *Other*_____
Last Physical/Wellness visit: _____
Breast cancer screening: □ Mammogram, Date_____ □ Self breast exams □ All normal
Cervical cancer screening/Pap smear: Date _____ □ All normal □ Abnormal result
Colon cancer screening: □ Colonoscopy Date _____□ Stool Card Next Due _____
Prostate cancer screening: □ PSA(lab) □ Prostate exam
Other: □ Heart tests □ Lung cancer screen □ Osteoporosis □ Endoscopy □ AAA □ Vision

Marital status: □ Married □ Domestic Partner □ Relationship □ Single □ Divorced □ Widowed
Do you feel safe at home? □ Yes □ No, safety concerns _____
Occupation/work: _____

Drugs/Alcohol:

□ Never □ Rare □ Occasional □ Regular □ Heavy / Binge □ Recovery

Substance, amount, and frequency: _____

Caffeine/Energy drinks:

□ Coffee (cups/day) □ Energy Drinks (amount) □ Soda/Pop/Cola (amount)

_____ _____ _____

Other _____

Describe your nutrition/diet and exercise:

_____

_____

_____

Female patients: Pregnancies #___ Births#___ Contraception/Birth control: _____

Advance Directives: □ Yes □ No □ Unsure □ Would like to discuss □ Declined

Allergies & Reactions: (medications, foods, etc.): □ **No known allergies**

_____

_____

Medication/Herb/Supplement/anything other than food: (attach list if available)

Drug & Dose	*Directions*	*For What?*

Vaccines: (attach records if available)

□ Tetanus (Td or Tdap) _____ □ Influenza (flu) _____ □ Shingles

□ Pneumonia: _____ _____ □ Hepatitis A series □ Hepatitis B series

□ HPV □ Other _____

Completed childhood immunizations: □ Yes □ No

Immunization reactions, egg allergies, asthma, immunosuppressed, or other vaccination issues?

_____

Reason for today's visit:_____