



**FALL CREEK
INTERNAL MEDICINE**

2160 NE WILLIAMSON COURT
BEND, OREGON 97701

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PATIENT MEDICAL HISTORY QUESTIONNAIRE

NAME		DOB	GENDER			MARITAL STATUS					
			M	F	Other	S	M	DP	D	W	
OCCUPATION				PREVIOUS PRIMARY CARE PROVIDER							

PERSONAL MEDICAL HISTORY (√ Y or N for each)											
	YES	NO		YES	NO		YES	NO		YES	NO
Abnormal PAP	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Chem. Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia/Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	STD _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness/Attempt Suicide	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Joint Issues	<input type="checkbox"/>	<input type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Issues	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Breast lump	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Infections	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraine	<input type="checkbox"/>	<input type="checkbox"/>						
Type _____											
<input type="checkbox"/> OTHER:											

FAMILY HISTORY				SOCIAL/SAFETY HISTORY	
Blood Relative	Alive	Age	Illness or cause of death		
Father	Y N			Do you use tobacco? <input type="checkbox"/> Present <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Year quit _____	
Mother	Y N			How much per day? ____ Packs <input checked="" type="checkbox"/> ____ Years	
Brother	Y N			Are you exposed to secondhand smoke in home? <input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> Never	
Brother	Y N			Do you use alcohol? <input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> Never if so, how much? _____	
Sister	Y N			Do you use recreational or illegal drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, what _____	
Sister	Y N			Do you always wear a seatbelt? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Son	Y N			Are you sexually active? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Son	Y N			Are you using birth control? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Daughter	Y N			If yes, what type: _____	
Daughter	Y N			Have you ever been abused? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Other:	Y N			Do you feel safe at home <input type="checkbox"/> YES <input type="checkbox"/> NO	
Other:	Y N				

YEAR	SURGERIES and HOSPITALIZATIONS

I certify that all the information is correct to the best of my knowledge. I will not hold my doctor or any staff responsible for any errors or omissions I may have made in the completion of this form.

Patient Signature _____ Date: _____

