



**FALL CREEK
INTERNAL MEDICINE**

2160 NE WILLIAMSON COURT
BEND, OREGON 97701

Kathryn K. Kocurek MD
Patricia A. Nibler MD
Kristin M. VanDomelen MD
Brittany Leila Perry MD

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
Abnormal PAP	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<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"/>
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"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<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"/>
Angina/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<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"/>
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"/>
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"/>
Back/Neck Issues	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Neuropathy	<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"/>
Breast lump	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Type _____						Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> OTHER:						Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
						Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>
						Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
						Speech/Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
						STD _____	<input type="checkbox"/>	<input type="checkbox"/>
						Stroke	<input type="checkbox"/>	<input type="checkbox"/>
						Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
						Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
						Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
						Vaginal Infections	<input type="checkbox"/>	<input type="checkbox"/>

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 second hand 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: _____



**FALL CREEK
INTERNAL MEDICINE**

2160 NE WILLIAMSON COURT
BEND, OREGON 97701

Kathryn K. Kocurek MD
Patricia A. Nibler MD
Kristin M. VanDomelen MD
Brittany Leila Perry MD

NAME: _____

DATE: _____

CURRENT MEDICATION LIST		
Name of Medication/Supplement	Reason for Medication/Supplement	Dosage and How Often Taken

ALLERGIES	
Name of Medication and/or Substance	Type of Reaction

OTHER TREATING CLINICIANS (Physical Therapists, Naturopaths, Gynecologists, Cardiologists, etc.)