



MALHEUR MEMORIAL
HEALTH CENTER
410 S. MAIN STREET
NYSSA, OR 97913

PATIENT HISTORY FORM

Patient Name: _____ DOB: _____ Date: _____

CURRENT MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what?

MEDICATIONS:

PHARMACY:

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug Dose (include strength & number of pills per day) How long have you been taking this?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other medical conditions (please list):

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL

- ☐ Recent weight gain; how much _____
- ☐ Recent weight loss: how much _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES

- ☐ Numbness
 - ☐ Joint pain
 - ☐ Muscle weakness
 - ☐ Joint swelling
- Where?

EARS

- ☐ Ringing in ears
- ☐ Loss of hearing

EYES

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness

THROAT

- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw

HEART AND LUNGS

- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Swollen legs or feet
- ☐ Cough

NERVOUS SYSTEM

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling
- ☐ Memory loss

STOMACH AND INTESTINES

- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

SKIN

- ☐ Redness
- ☐ Rash
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet

BLOOD

- ☐ Anemia
- ☐ Clots

KIDNEY/URINE/BLADDER

- ☐ Frequent or painful urination
- ☐ Blood in urine

Women Only:

- ☐ Abnormal Pap smear
- ☐ Irregular periods
- ☐ Bleeding between periods
- ☐ PMS

PSYCHIATRIC

- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulties with sexual arousal
- ☐ Poor appetite
- ☐ Food cravings
- ☐ Frequent crying
- ☐ Sensitivity
- ☐ Thoughts of suicide / attempts
- ☐ Stress
- ☐ Irritability
- ☐ Poor concentration
- ☐ Racing thoughts
- ☐ Hallucinations
- ☐ Rapid speech
- ☐ Guilty thoughts
- ☐ Paranoia
- ☐ Mood swings
- ☐ Anxiety
- ☐ Risky behavior

OTHER PROBLEMS:

WOMENS ONLY, REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
Cigarette or tobacco products					Yes <input type="checkbox"/> No <input type="checkbox"/>
ALCOHOL					Yes <input type="checkbox"/> No <input type="checkbox"/>
CANNABIS: Marijuana, hashish, hash oil					Yes <input type="checkbox"/> No <input type="checkbox"/>
STIMULANTS: Cocaine, crack					Yes <input type="checkbox"/> No <input type="checkbox"/>
STIMULANTS: Methamphetamine—speed, ice, crank					Yes <input type="checkbox"/> No <input type="checkbox"/>
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes <input type="checkbox"/> No <input type="checkbox"/>
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes <input type="checkbox"/> No <input type="checkbox"/>
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes <input type="checkbox"/> No <input type="checkbox"/>
HEROIN					Yes <input type="checkbox"/> No <input type="checkbox"/>
STREET OR ILLICIT METHADONE					Yes <input type="checkbox"/> No <input type="checkbox"/>
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes <input type="checkbox"/> No <input type="checkbox"/>
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes <input type="checkbox"/> No <input type="checkbox"/>
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes <input type="checkbox"/> No <input type="checkbox"/>
OTHER: (specify) _____ _____ _____					Yes <input type="checkbox"/> No <input type="checkbox"/>