



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:

- Diabetes
- High blood pressure
- High cholesterol
- Hypothyroidism
- Goiter
- Cancer (type) \_\_\_\_\_
- Leukemia
- Psoriasis
- Angina
- Heart problems

- Heart murmur
- Pneumonia
- Pulmonary embolism
- Asthma
- Emphysema
- Stroke
- Epilepsy (seizures)
- Cataracts
- Kidney disease
- Kidney stones

- Crohn's disease
- Colitis
- Anemia
- Jaundice
- Hepatitis
- Stomach or peptic ulcer
- Rheumatic fever
- Tuberculosis
- HIV/AIDS

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?
<b>Cigarette or tobacco products</b>					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>ALCOHOL</b>					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>CANNABIS:</b> Marijuana, hashish, hash oil					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>STIMULANTS:</b> Cocaine, crack					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>STIMULANTS:</b> Methamphetamine—speed, ice, crank					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>AMPHETAMINES/OTHER STIMULANTS:</b> Ritalin, Benzedrine, Dexedrine					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>BENZODIAZEPINES/TRANQUILIZERS:</b> Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>SEDATIVES/HYPNOTICS/BARBITURATES:</b> Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>HEROIN</b>					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>STREET OR ILLICIT METHADONE</b>					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>OTHER OPIOIDS:</b> Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>HALLUCINOGENS:</b> LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>INHALANTS:</b> Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>OTHER:</b> (specify) _____ _____ _____					Yes <input type="checkbox"/> No <input type="checkbox"/>