FALL CREEK
INTERNAL MEDICINE

2160 NE WILLIAMSON COURT
BEND, OREGON 97701

Kathryn K. Kocurek MD
Patricia A. Nibler MD
Laura Nicholson MD
Kristin M.VanDomelen 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 | | YES NO |
|---|---|---|---|---|---|---|---|
| Abnormal PAP | □ □ | Cataracts | □ □ | Hernia | □ □ | Pneumonia/Bronchitis | □ □ |
| AIDS/HIV | □ □ | Chem. Dependency | □ □ | Hepatitis | □ □ | Prostate Problems | □ □ |
| Acid Reflux | □ □ | Chronic Constipation | □ □ | High Blood Pressure | □ □ | Rheumatic Fever | □ □ |
| Alcoholism | □ □ | Chronic Diarrhea | □ □ | High Cholesterol | □ □ | Sinus Infections | □ □ |
| Anemia | □ □ | Depression | □ □ | Kidney Disease | □ □ | Sleep Apnea | □ □ |
| Angina/Heart Attack | □ □ | Diabetes | □ □ | Liver Disease | □ □ | Speech/Hearing Problems | □ □ |
| Anorexia/Bulimia | □ □ | Emphysema/COPD | □ □ | Memory Loss | □ □ | STD _____ | □ □ |
| Asthma | □ □ | Epilepsy/Seizures | □ □ | Mental Illness/Attempt Suicide | □ □ | Stroke | □ □ |
| Arthritis/Joint Issues | □ □ | Erectile Dysfunction | □ □ | Neurologic Disorder | □ □ | Thyroid Problems | □ □ |
| Back/Neck Issues | □ □ | Glaucoma | □ □ | Numbness/Neuropathy | □ □ | Ulcers | □ □ |
| Bleeding disorders | □ □ | Gout | □ □ | Osteoporosis/Osteopenia | □ □ | Urinary Problems | □ □ |
| Breast lump | □ □ | Heart Problems | □ □ | Pacemaker | □ □ | Vaginal Infections | □ □ |
| Cancer | □ □ | Headaches/Migraine | □ □ | | | | |

Type_____

□ **OTHER:**

## FAMILY HISTORY

| Blood Relative | Alive | Age | Medical Conditions |
|---|---|---|---|
| Father | Y N | | |
| Mother | Y N | | |
| Brother | Y N | | |
| Brother | Y N | | |
| Sister | Y N | | |
| Sister | Y N | | |
| Son | Y N | | |
| Son | Y N | | |
| Daughter | Y N | | |
| Daughter | Y N | | |
| Other: | Y N | | |
| Other: | Y N | | |

## SOCIAL/SAFETY HISTORY

Do you use tobacco?
□ Present □ Never □ Past □ Year quit_____
How much per day?_____Packs **X** _____ Years
Are you exposed to second hand smoke in home?
□ Past □ Present □ Never
Do you use alcohol?
□ Past □ Present □ Never if so, how much? _____
Do you use recreational or illegal drugs?
□ YES □ NO If so, what_____
Do you always wear a seatbelt? □ YES □ NO
Are you sexually active? □ YES □ NO
Are you using birth control? □ YES □ NO
If yes, what type:_____
Have you ever been abused? □ YES □ NO
Do you feel safe at home □ YES □ NO

| YEAR | SURGERIES and HOSPITALIZATIONS |
|---|---|
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| | |

**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:** _____

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**NAME: _____** **DATE: _____**

| CURRENT MEDICATION LIST | | |
|---|---|---|
| **Name of Medication/Supplement** | **Reason for Medication/Supplement** | **Dosage and How Often Taken** |
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| ALLERGIES | |
|---|---|
| **Name of Medication and/or Substance** | **Type of Reaction** |
| | |
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| OTHER TREATING CLINICIANS<br>(Physical Therapists, Naturopaths, Gynecologists, Cardiologists, etc.) |
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