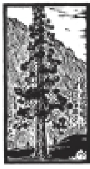


FALL CREEK
INTERNAL MEDICINE

2160 NE WILLIAMSON COURT
BEND, OREGON 97701

Kathryn K. Kocurek MD
Patricia A. Nibler MD
Kristin M. VanDomelen MD
Brittany Leila Perry, MD
Erin J. Montgomery PA-C

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	Illness or cause of death
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		

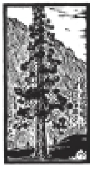
SOCIAL/SAFETY HISTORY

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

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**

ALLERGIES	
Name of Medication and/or Substance	**Type of Reaction**

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