ROGUE RIVER
FAMILY PRACTICE CLINIC

509 E. Main Street
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541-582-0505

HEALTH HISTORY

Name _____ Date _____

Date of birth _____ Referred by _____

Are you under the care of any other physician/provider? ☐ Yes ☐ No

Please list other health care providers _____

_____

SOCIAL HISTORY

Do you use tobacco? ☐ Yes ☐ No Average amount (daily, weekly, or monthly) _____

Do you drink alcohol? ☐ Yes ☐ No Average amount (daily, weekly, or monthly) _____

WOMEN ONLY

First menstrual cycle (age) _____ Present form of birth control _____

Date of last menstrual cycle _____ # of pregnancies _____ Full-term _____ Live births _____

Date of last mammogram _____ Date of last pap smear _____

MEN ONLY

Date of last prostate exam _____ Date of last PSA test _____

Date of last colonoscopy _____ Date of last Dexa Scan _____

PAST MEDICAL HISTORY *(check all that apply)*

☐ Coronary artery disease
☐ Heart rhythm
☐ Heart infections/Inflammation
☐ Heart malformations
☐ High blood pressure
☐ Heart muscle disorders
☐ Other _____
☐ Diabetes Type I
☐ Diabetes Type II
☐ Hypothyroidism
☐ Psychiatric condition
☐ Cancer (type and location) _____

DIABETIC PATIENTS

Date of last foot exam _____ Date of last eye exam _____

Date of last A1c _____ Date of last cholesterol panel _____

Name _____ Date of Birth _____ Today's Date _____

PREVIOUS SURGERIES

	Type	Year	Surgeon	City
1				
2				
3				
4				
5				
6				
7				

FAMILY HISTORY

IF LIVING

Father Age _____ Health _____

Mother Age _____ Health _____

IF DECEASED

Father Age at Death _____ Cause _____

Mother Age at Death _____ Cause _____

# of Children _____ # living _____ # deceased _____ Ages of each _____

Serious illnesses of children _____

_____

FAMILY MEDICAL HISTORY *(Please check and note relationship. If grandparent, please specify maternal or paternal.)*

- ☐ Coronary artery disease
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- ☐ Other _____
- ☐ Diabetes Type I
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