# HEALTH HISTORY

One Family medical group

Legal name _____ Preferred name _____ Today's date _____

*Please fill out both pages of this health history form. The information you provide will remain confidential.*

## HAVE YOU EVER HAD THE FOLLOWING? *(Circle below all that apply)*

| | | | | |
|---|---|---|---|---|
| Abnormal PAP | Drug or Alcohol Problem | Heart Disease | Kidney disease | Trauma |
| Arthritis | Emphysema | Hepatitis B | Liver disease | Tuberculosis |
| Asthma | Epilepsy | Hepatitis C | Osteoporosis | |
| Blood transfusion | Gastric Ulcer | HIV | Prostate problems | Other: _____ |
| DVT | GERD | High cholesterol | Rheumatoid Arthritis | _____ |
| Depression | Gout | High blood pressure | Stroke | _____ |
| Diabetes | Heart Attack | Irritable bowel | Thyroid disease | _____ |

## HAVE YOU EVER HAD CANCER? ☐ No ☐ Yes *(Which kind)* _____

## WHEN WAS YOUR LAST...

| Test | Never / NA | Approx .Year |
|---|---|---|
| Tetanus shot | | |
| Pneumonia vaccine | | |
| Colonoscopy | | |
| Pap smear | | |
| Bone mineral density | | |
| Mammogram | | |
| PSA | | |
| Hepatitis | | |
| STD | | |

## SURGERY/PROCEDURE LIST

| Surgery/Procedure | Year performed |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## MEDICATIONS *(Please list all medications you take regularly)*

**Preferred Pharmacy** _____

| Medication | Dose | Frequency (how often) | Prescribing physician (or over-the-counter) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## YOUR PERSONAL APPROACH TO HEALTH CARE...

| | | | |
|---|---|---|---|
| **Treatment / Medications** | ☐ Only when necessary | ☐ Evidence based and preventative | ☐ Alternative |
| **Testing & Screening** | ☐ Not interested in most | ☐ Evidence based tests only | ☐ Would like everything looked at |
| **Patient Education** | ☐ Just what i need to get by | ☐ Basic info on all of my conditions | ☐ As much info as possible |

Tori Rumrey, FNP | Doreen Gordon, FNP

1619 NW Hawthorne Ave., Suite 203, Grants Pass, Oregon 97526 | Phone 541.474.5511 | Fax 541.472.3225

# HEALTH HISTORY *(cont.)*

One Family medical group

## OHRP INFORMATION *(required by the State)*

Race ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ White ☐ Prefer not to answer

Ethnicity ☐ Hispanic or Latino ☐ Non-hispanic or Latino ☐ Unknown ☐ Prefer not to answer

## MEDICATION ALLERGIES *(Please list all medication allergies and the reaction you have if you take them)*

| Allergic to: | Reaction | Allergic to: | Reaction |
|---|---|---|---|
| | | | |
| | | | |

## FAMILY HEALTH HISTORY?

Are you adopted? ☐ Yes ☐ No

Has any blood relative had any of the following? *(Circle the condition and indicate the family member who has had it.)*

| Condition | Family member(s) *(example: maternal grandmother)* | Condition | Family member(s) *(example: maternal grandmother)* |
|---|---|---|---|
| Asthma | | Heart disease | |
| Blood disorder | | High cholesterol | |
| Cancer *(what kind?)* | | Drug or Alcohol | |
| Mental health problems | | Stroke | |
| Diabetes | | Tuberculosis | |
| Kidney disease | | Other: | |

## SOCIAL HISTORY

Highest level completed in school: _____ What is your occupation: _____

Do you smoke? ☐ Never ☐ Quit – When? _____ ☐ Yes – How much per day _____

Do you drink alcohol? ☐ Never ☐ Quit – When? _____ ☐ Yes – How much per day _____

Do you exercise? ☐ Sedentary ☐ 1 – 2x/month ☐ 1 – 2x/week ☐ 3 – 4x/week ☐ Nearly daily ☐ Daily

Have you completed a living will or advance directive? ☐ No ☐ Yes *(If so please bring copy for your records)*

## SEX ASSIGNED AT BIRTH

☐ Female ☐ Male ☐ Intersex

Menopause? ☐ N/A ☐ No ☐ Yes, since age _____

Date of last period _____ ☐ N/A

How many children have you had? _____

Full term births ? _____

## BIRTH CONTROL METHOD

☐ Not active ☐ None B.C. _____

## SEXUAL ORIENTATION

☐ Heterosexual ☐ Lesbian ☐ Bisexual ☐ Gay

☐ Monogomous ☐ Pansexual ☐ Polyamorous

☐ Other: _____

Please tell us a little about yourself and your biggest healthcare concerns:

_____

_____

_____

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