CANBY HEALTHCARE CLINIC LLC

Patient Information **Date: / /** **Medical Record #:**

Patient Name: _____

Preferred Name: _____ Sex: ___ Male ___ Female

Date of Birth: _____/_____/_____ Marital Status: ___Married ___ Single ___ Divorced ___ Widowed

Do you have any health concerns? If yes, please list: _____

_____

_____

Past Medical History

Check conditions that doctors have followed you for in the past:

___ High blood pressure/ hypertension	___ Thyroid problems	___ Mitral valve prolapse	___ Reflux disease
___ High cholesterol	___ Kidney disease	___ Stroke	___ Glaucoma
___ Liver disease	___ Heart attack/ Bypass	___ Seizures/ Epilepsy	___ Psychiatric illness
___ Diabetes ("sugar")	___ Heart failure	___ Stomach problems	___ Arthritis
	___ Heart murmur	___ Intestinal problems	___ Abnormal Pap

___ Cancer (type and location): _____

___ Other: _____

List any hospitalizations or surgeries you have had (including C-section): _____

_____

_____

List any drug allergies: _____

_____

Are you allergic to latex? ___ Yes ___ No

List all current medications (including vitamins, herbal supplements, and health food preparations):

_____

_____

_____

_____

_____

Preventive Care

When was your last: Tetanus Booster: _____ Flu Shot: _____ Pneumonia Vaccine: _____

Hepititis Vaccine: _____ Flexible Sigmoidoscopy/ Colonoscopy _____ Bone Densitometry _____

Female Only

Do you perform breast self-exams? _____ Do you see an OB-GYN doctor? _____

When was your last mammogram? _____ When was your last Pap smear? _____

Male Only

Do you do a testicular exam? _____ Do you have any problem with erections? _____

When was your last prostate blood test (PSA)? _____ When was your last prostate/rectal exam? _____

Partner Violence Screen

Have you been hit, kicked, punched or otherwise hurt by someone within the last year?:Yes_____No:_____

Do you feel safe in your present relationship?: Yes:_____No:_____

Is there a partner from a previous relationship who is making you feel unsafe now?: Yes:_____No:_____

Social Habits

Have you ever used tobacco products? __ Yes __ No

What kind? _____

How much? _____

For how many years? _____

Date quit _____

How many glasses/cups of caffeine do you drink daily?_____

Do you drink alcohol? __ Yes __ No

How many drinks per week? _____

Have you ever felt the need to cut down? _____

Have you ever felt guilty about your drinking? _____

Do you use drugs? __ Yes __ No

What type? _____ How often? _____

Do you exercise outside of your job? _____ Do you wear seatbelts? __Always __Usually __Sometimes __Never

What is your occupation? _____

How do you learn best? __Read it __Tell me __Show me How much education have you completed? _____

Family History

Check the appropriate boxes.

Condition	Mother	Father	Grandparent	Sibling	Other
High Blood Pressure/Hypertension					
Heart Attack/ Heart Surgery					
Diabetes					
Stroke					
Cancer (Type/Location)					
Osteoporosis					
Thyroid Problems					
Mental Illness					
Glaucoma					

Please check any of the following problems that apply to you: ___ **No problems**

General
__Fever
__Sweats

Allergy
__Seasonal symptoms
__Sneezing
__Itchy eyes
__Runny nose
__Nasal congestion
__Postnasal drip

Cardiovascular
__Chest pain or pressure
__Ankle swelling
__Palpitations

Ear/ Nose/ Throat
__Ear pain
__Runny nose
__Sneezing
__Postnasal drip

Eyes
__Blurred vision
__Changing vision

Endocrine
__Excessive urination
__Excessive thirst
__Fatigue
__Heat intolerance
__Cold intorlerance

Genitourinary
__Urinary frequency
__Burning with urination
__Blood in urine
__Problems urinating
__Awaken at night to urinate
__Problems with sex
__Exposure to sexually transmitted disease

Respiratory
__Cough
__Shortness of breath
__Wheezing
__Shortness of breath with exertion

Gastrointestinal
__Nausea
__Vomiting
__Constipation
__Abdominal pain
__Diarrhea
__Blood in stool

Hematologic
__Easy bruising
__Easy bleeding
__Hard to stop bleeding

Musculoskelatal
__Joint swelling
__Joint pains
__Muscle pains

Nurologic
__Numbness
__Tingling
__Headaches
__Weakness

Skin
__Rash
__Changing mole
__Itching
__Slow-healing wounds

Nutrition
__On a special diet
__Weight gain or loss greater than 10 pounds

Mental Health
__Insomnia
__Guilt
__Depression
__Anxiety
__Suicidal thoughts

Daily Living
__Violence in your home
__Changes in functional ability
__Changes in eating habits
__Changes in sleeping habits