



ADVANCED SPECIALTY CARE

2084 N.E. PROFESSIONAL COURT
BEND, OR 97701 ■ (541) 322-5753

236 N.W. KINGWOOD AVE. ■ SUITE A
REDMOND, OR 97756 ■ (541) 548-7743
WWW.ADVANCEDSPECIALTYCARE.COM

GENERAL HEALTH HISTORY

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M F

What is your main reason for making this appointment? _____

Primary Care Doctor: _____ Primary Pharmacy: _____

Occupation: _____ Current Employer: _____

Last grade of school completed: _____ What hobbies/recreational interests do you have? _____

Medications

Medication Name	Strength (mg, etc.)	How often taken	Prescribing Doctor

Drug Allergies / Tolerances

Medication Name	Reaction

Past Medical History: If you have ever had any of the following medical conditions, please check them and write in the appropriate date that you were first told you had the problem.

- | | |
|---|---|
| <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> Heart Murmur: _____ |
| <input type="checkbox"/> Thyroid Disease: _____ | <input type="checkbox"/> Hepatitis: _____ |
| <input type="checkbox"/> High Cholesterol: _____ | <input type="checkbox"/> Rheumatic Fever: _____ |
| <input type="checkbox"/> Angina / Heart Attack: _____ | <input type="checkbox"/> HIV + / AIDS: _____ |
| <input type="checkbox"/> High Blood Pressure: _____ | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Other: _____ | |

Surgeries

Do you smoke tobacco? Y N Packs / cigarettes per day? _____

Do you drink alcohol? Y N Current drinks per week: _____ Caffeine: _____

Illegal drug use in the past or present? _____ Counseling or psychiatric care? _____

Family History: Has any blood relative had any of the following problems? (please check any that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sudden Death |

Family Member History

	Living	Deceased	Current Age / Age at Death	Cause of Death
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brother / Sisters	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Grandparents (Maternal / Paternal)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Do any of your children have health problems?	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____	
			(please explain)	

Please check any of the conditions / symptoms listed below that you have had in the past 6 months.

General

- Unusual fatigue or weakness
- Chills / fever
- Bleeding tendency
- Hot or cold intolerance

Eyes

- Eye Pain
- Double / blurred vision
- Blind areas

Ears

- Hearing loss
- Ear ache
- Ringing in ears

Throat / Mouth

- Sore mouth, tongue, lips
- Hoarseness
- Difficulty swallowing

Heart

- Irregular / skipped beats
- Racing or flutter
- Pounding heart
- Chest pain
- Murmur
- Swollen feet / ankles

Nervous System

- Dizziness
- Blackouts
- Nervousness
- Trembling or shakiness
- Numbness / tingling, where? _____
- Paralysis
- Seizures

Bones / Joints / Muscle Problems

- Painful or stiff joints
- Muscle cramps / aching
- Back pain
- Varicose veins

Breast

- Lump, pain or discharge

Lungs

- Persistent cough
- Coughing up blood, mucus or pus
- Shortness of breath
- Wheezing
- Difficulty swallowing while laying down

Stomach / Digestive Tract

- Frequent indigestion or heartburn
- Nausea / vomiting
- Diarrhea / constipation
- Black stool
- Abdominal pain / cramping / stomach ache

Urinary Tract

- Pain or burning while urinating
- Night frequency / urination
- Slow starting or stopping urine stream
- Discharge / bloody or dark urine
- Sexual problem

Mood

- Depression
- Irritability
- Lack of memory
- Stress / tension
- Anger

Menstrual

- Last menstrual cycle:
- Age at onset:
- Last mammogram:
- Last PAP:

Additional Comments
