WesternU Health
Oliver Station

# Health History Form

5909 SE 92ND AVE
PORTLAND, OR 97266

NAME:_____ DOB: _____ DATE: _____

PREFERRED PHARMACY (MAIL ORDER AND LOCAL):_____

_____

_____

_____

| CURRENT MEDICATIONS (including supplements, over-the-counter (OTC) and herbs) | | |
|---|---|---|
| NAME | DOSE | FREQUENCY |
| | | |
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PORTLAND, OR 97266

NAME:_____ DOB: _____ DATE: _____

| ALLERGIES (MEDICATIONS, FOOD AND ENVIRONMENTAL) | |
|---|---|
| SOURCE | REACTION |
| | |
| | |
| | |
| | |
| | |

| SURGICAL HISTORY | | |
|---|---|---|
| TYPE OF SURGERY/PROCEDURE | DATE | PROVIDER |
| | | |
| | | |
| | | |
| | | |
| | | |

*If applicable, please provide the most recent dates of these screenings.*

LAST COLONOSCOPY:_____ LAST BONE DENSITY (DEXA) SCAN:_____

LAST MAMMOGRAM:_____ LAST PAP SMEAR:_____

## SUBSTANCE USE

SMOKING: ☐ Never ☐ Former ☐ Every Day ☐ Some Days READY TO QUIT? ☐ Yes ☐ No

TYPE: ☐ Cigarettes ☐ Pipe ☐ Cigars

Start Date:_____ Start Date:_____ Start Date:_____

Quit Date:_____ Quit Date:_____ Quit Date:_____

Packs per day:_____ Years:_____

SMOKELESS: ☐ Never ☐ Former; Quit Date:_____ ☐ Current: ☐ Chew ☐ Snuff

E-CIGARETTES/VAPING: ☐ Never ☐ Former; Quit Date:_____ ☐ Every Day ☐ Some Days

ALCOHOL: ☐ Yes; Drinks per Week: _____ ☐ Not Currently ☐ Never

DRUG USE: ☐ Yes ☐ Not Currently ☐ Never

TYPES:_____

USE PER WEEK:_____

COMMENTS:_____

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NAME:_____ DOB: _____ DATE: _____

| MEDICAL CONDITIONS: Circle any of the following conditions that you have been diagnosed with | | | | |
|---|---|---|---|---|
| Acid Reflux/Heartburn | Anemia | Asthma | Cancer (Type) | Congestive Heart Failure |
| Depression and/or Anxiety | Diabetes | Drug/Alcohol Use Disorder | Heart Disease | Hepatitis |
| High Blood Pressure | High Cholesterol | Lung Disease | Stroke | Thyroid Disease |
| Other(s): | | | | |

| OTHER DOCTORS AND SPECIALISTS (Patient Care Team) | | | |
|---|---|---|---|
| Specialist Type | Provider/Facility | Specialist Type | Provider/Facility |
| Eye Doctor | | GYN/OB | |
| Dermatology | | Gastroenterology | |
| Cardiology | | Rheumatology | |
| Endocrinology | | Nephrology | |
| Neurology | | Pulmonology | |
| Urology | | Other | |

| FAMILY MEDICAL HISTORY | | | |
|---|---|---|---|
| FAMILY MEMBER | AGE | ALIVE? | SIGNIFICANT HEALTH PROBLEMS |
| Mother | | ☐Yes ☐No | |
| Father | | ☐Yes ☐No | |
| Sibling(s): ☐Male ☐Female | | ☐Yes ☐No | |
| Sibling(s): ☐Male ☐Female | | ☐Yes ☐No | |
| Children: ☐Male ☐Female | | ☐Yes ☐No | |
| Children: ☐Male ☐Female | | ☐Yes ☐No | |
| Other: ☐Male ☐Female | | ☐Yes ☐No | |
| Other: ☐Male ☐Female | | ☐Yes ☐No | |