The Corvallis Clinic™

Health Questionnaire

The following information will help your physician in reviewing your personal health, family history, and your current health habits. This will be kept in strict confidence and made part of the medical record. Please give it to your physician at the time of your appointment.

Last Name..... First Name .....

Date of Birth..... Phone..... Date.....

Briefly List Current Symptoms/Complaints.....

.....

Social History:

Place of Birth..... Religion.....

Education (Highest Level) ..... Occupation..... How Long.....

Marital Status: Single..... Widowed..... Married ..... How Long..... Unmarried/Partner .....

Previous Marriage(s)..... How Long.....

Personal History:

Check any of the illnesses/medical conditions you have had:

❑ Anxiety	❑ Diabetes	❑ Hemorrhoids	❑ Pneumonia	❑ Stroke
❑ Arthritis	❑ Emphysema	❑ Hiatal Hernia	❑ Rectal Bleeding	❑ Thyroid Disease
❑ Asthma	❑ Epilepsy	❑ High Blood Pressure	❑ Rheumatic Fever	❑ Tuberculosis
❑ Chronic Bronchitis	❑ Hay Fever	❑ High Cholesterol	❑ Stomach Ulcers	
❑ Colon Polyps	❑ Headaches	❑ Irritable Bowel	❑ Cancer Type.....	
❑ Depression	❑ Heart Attack/Angina	❑ Kidney Disease	❑ Other:	

List all surgeries/operations/hospitalizations:

Type	Year	Hospital/City, State

For Women Only:

Number of Pregnancies..... Number of Living Children.....

Number of Miscarriages..... Number of Therapeutic Abortions .....

Number of Cesarean Births ..... Date of Last Period.....

Date of Last PAP Smear..... Date of Last Mammogram .....

Medications (List your current prescriptions and over the counter medications):

Medications	Dose	How Often	Reason

Allergies (If so, please describe the reaction, e.g. rash):

.....

Immunization History (List last date of immunization):

Influenza Vaccine (flu shot)..... Diphtheria/Tetnanus .....

Pneumovax (pneumonia)..... Other .....

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MD1360 (10/17) General Health

Habits (Y=Yes, N=No):

Cigarette Smoking?	Y or N	# packs per day?..... Number of Years?……..
Smokeless Tobacco?	Y or N	How much/often?..... Number of Years?……..
Quit Nicotine Use	Y or N	When? ……..
Alcohol Use?	Y or N	How much/often…… How many years?……..
Quit Alcohol Use?	Y or N	When?.....
Caffeine Use?	Y or N	Type?..... How much/often?…….
Drug Use?	Y or N	Type?..... How much/often?…….
Exercise?	Y or N	Type?..... How often?……..

Review of Systems (Please mark all that apply):

General: ❑ Fatigue ❑ Fevers ❑ Malaise ❑ Weakness

Head, Eyes, Ears, Nose, Throat, Lymph Nodes:

❑ Deafness ❑ Nasal and/or sinus congestion ❑ Sneezing
❑ Double vision ❑ Neck stiffness ❑ Sore throat
❑ Glaucoma ❑ Neck swelling ❑ Swollen and/or painful lymph nodes
❑ Head trauma ❑ Nose bleeds ❑ Tinnitus (buzzing or humming)
❑ Headaches ❑ Pain and/or drainage from ears ❑ Visual Loss or changes
❑ Hoarseness of voice ❑ Photophobia (light bothers eyes)

Respiratory System:

❑ Cough ❑ Hemoptysis ❑ Shortness of breath
❑ Sputnum/secretion production ❑ Wheezing

Cardiovascular System:

❑ Chest pain, discomfort, heaviness, tightness ❑ Hemoptysis
❑ Palpitations ❑ PND (waking up short of breath) ❑ Shortness of breath with exertion

Gastrointestinal System:

❑ Abdominal pain ❑ Dysphagia (difficulty swallowing) ❑ Melena (black bowel movements)
❑ Anorexia (poor appetite) ❑ Hematochezia (red blood in bowel movements)
❑ Nausea and/or vomiting ❑ Constipation or diarrhea ❑ Jaundice ❑ Weight loss or gain

Genitourinary System:

❑ Frequent Urination ❑ Noctuia (urination at night) ❑ Pyuria (cloudy urine)
❑ Heavy menstrual flow ❑ Oliguria (infrequent urination) ❑ Urgency (sensation to urinate)
❑ Hematuria (blood in urine) ❑ Polyuria (urination of large volumes)
❑ Incontinence

Nervous System:

❑ Memory loss, sleep disturbance, mood disorders (anxiety/depression)
❑ Pain and/or parathesias (tingling or numbness)
❑ Urinary and/or fecal incontinence (wet or soil underwear)
❑ Weakness/paralysis one side of body

Musculoskeletal System: ❑ Back pain ❑ Joint pain ❑ Muscle aches and pains

Dermatological System:

❑ Bleeding or bruising ❑ Breast pain ❑ Mole changes ❑ Pruritus (itching)
❑ Breast lumps ❑ Changes in nipples ❑ Pigmentation (change in color)
❑ Rash

Family History:

		Present health or cause of death
Father Living? Y or N Age.....		.....
Mother Living? Y or N Age.....		.....
How many brothers living?.....	Present Health	.....
How many brothers deceased?	Cause of Death	.....
How many sisters living?.....	Present Health	.....
How many sisters deceased?.....	Cause of Death	.....
How many children living?	Present Health	.....
How many children deceased?.....	Cause of Death	.....

Do you know of any blood relatives who have or had the following? (Please circle and give the relationship.)

Anesthesia Reaction	.....	Depression	.....	Migraines	.....
Arthritis	.....	Diabetes	.....	Stroke	.....
Asthma	.....	Epilepsy	.....	Suicide Attempt	.....
Bleeding Problems	.....	Heart Attack/Angina	.....	Thyroid Disease	.....
Cancer (type)	.....	High Blood Pres.	.....	Tuberculosis	.....
Colitis	.....	High Cholesterol	.....	Ulcers	.....
Colon Polyps	.....	Other	.....		

Patient Signature..... Physician Signature.....

Date ..... Date.....