The Corvallis Clinic™
PHYSICIANS & SURGEONS

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. Thank you for your consideration.

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

Date of Birth: ..... Home Phone Number: ..... Dated .....

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.....

Briefly List Current Symptoms/Complaints .....

Personal History

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

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

Medication	Dose	How Often	Reason
.....			
.....			
.....			
.....			
.....			
.....			
.....			

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

.....

Immunization History (List date of last immunization): Influenza Vaccine (flu shot) .....

Diptheria/Tetanus ..... Pneumovax (pneumonia) .....

Other .....

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541-754-1260
MD1360 (01/12) General Health

Name .....

Patient ID# .....

(over)

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: ❑ Fevers ❑ Weakness ❑ Fatigue ❑ Malaise

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

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

Respiratory System:

❑ Shortness of breath ❑ Wheezing ❑ Cough
❑ Sputum/secretion production ❑ Hemoptysis (coughing up blood)

Cardiovascular System:

❑ Chest pain, discomfort, heaviness, tightness ❑ Palpitations
❑ Shortness of breath with exertion ❑ Orthopnea (sleeping on two or more pillows)
❑ PND (waking up short of breath) ❑ Leg swelling

Gastrointestinal System:

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

Genitourinary System:

❑ Hematuria (blood in urine) ❑ Polyuria (urination of large volumes of urine)
❑ Oliguria (infrequent urination) ❑ Nocturia (urination at night) ❑ Pyuria (cloudy urine)
❑ Incontinence ❑ Frequency (frequent urination) ❑ Urgency (sensation to urinate)
❑ Heavy menstrual flow ❑ Last menstrual period . . . . . .

Nervous System:

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

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

Dermatological System:

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

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 any blood relatives who have or had the following? Please circle and give relationship

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

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

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