ASHLAND
FAMILY PRACTICE

Cindy Parks-Landis, FNP
Jennifer Moss, FNP
Anne Taylor, FNP
Sharon Scelza, FNP

935 SISKIYOU BLVD.
ASHLAND, OR 97520
(541) 482-2716

Health History Information

Today's Date:_____ **Patient ID#:**_____

Patient Name:_____ **Birth Date:**_____

Preferred Local Pharmacy: _____ **Mail Order Pharmacy:**_____

Advance Directive on file with us? No__ Yes__ **POLST form on file with us? No__ Yes__**

Other Health Care Providers (please list any other care providers you are currently seeing)**:**

_____

Past Medical History

Have you ever had any of the following: (Check "no" or "yes", leave blank if uncertain)

Congestive Heart Failure.. ☐No ☐Yes
Atrial Fibrillation……..… ☐No ☐Yes
Coronary Artery Disease... ☐No ☐Yes
Valvular Disease…… ☐No ☐Yes
Arthritis……..... ☐No ☐Yes
Venereal Disease…… ☐No ☐Yes
Anemia……..... ☐No ☐Yes
Bladder Infections…….. ☐No ☐Yes
Epilepsy…….. ☐No ☐Yes
Migraine Headaches..... ☐No ☐Yes
Diabetes I or II……..…….. ☐No ☐Yes
Last Foot/Eye Exam _____
Hemoglobin A1c _____

Polio…….. ☐No ☐Yes
Glaucoma…….. ☐No ☐Yes
Hernia…… ☐No ☐Yes
Blood or Plasma
Transfusions…… ☐No ☐Yes
Back Trouble…… ☐No ☐Yes
High Blood Pressure…….. ☐No ☐Yes
Low Blood Pressure…….. ☐No ☐Yes
Hemorrhoids…….. ☐No ☐Yes
Asthma……..... ☐No ☐Yes
Hives or Eczema…… ☐No ☐Yes
AIDS or HIV +…….. ☐No ☐Yes
Implanted Device or Metal ☐No ☐Yes
If yes, type_____

Infectious Mono…… ☐No ☐Yes
Mitral Valve Prolapse……. ☐No ☐Yes
Stroke…….. ☐No ☐Yes
High Cholesterol……..… ☐No ☐Yes
If yes, last checked _____
Hepatitis…….. ☐No ☐Yes
Ulcer…….. ☐No ☐Yes
Kidney Disease…….. ☐No ☐Yes
Thyroid Disease…… ☐No ☐Yes
If yes, last thyroid panel _____
Bleeding Tendency……..... ☐No ☐Yes
Cancer…… ☐No ☐Yes
If yes, type_____
Other_____

Previous Hospitalizations/Surgeries/Serious Illness	**When?**	**Hospital, City, State**

Medications (include nonprescription supplements)_____

_____

_____

Allergies (List the following allergies, indicating any reactions):

Medications_____

Environmental/Known Food Allergies_____

Immunizations

List the date that you last received the following immunizations:

☐ Tetanus _____ ☐ Pneumovax _____ Hepatitis B 3-dose series: ☐1 ☐ 2 ☐ 3 complete
☐ Influenza (Flu) _____ ☐ Prevnar 13 _____ Shingrix 2-dose series: ☐1 ☐ 2 complete
☐ HPV _____

Preventative Screenings
List the date of your last screening:

☐ PSA (prostate cancer)	_____	☐ Mammogram	_____	☐ Colonoscopy	_____
☐ Pap	_____	☐ Dexa (bone density)	_____	☐ Hepatitis C	_____
☐ HIV	_____	☐ iFOBT (blood in stool)	_____	☐ Abdominal Aortic Aneurysm (AAA)	_____
☐ Chest X-ray	_____	☐ Lung CT	_____		

Biological Family Medical History:

Relationship	Age	Age at Onset	Diseases/Conditions	If Deceased, Cause of Death
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Patient Social History:

Relationship Status (check all that apply):

☐ Single ☐ In relationship(s) ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Sexually Active: ☐ No ☐ Yes - # of partners in the last 12 months_____

Sexual Orientation:_____

Recent Travel: ☐ No ☐ Yes - Where/When?_____

Exposure exposure at home/work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Air-borne Particles ☐ Noise

Use of alcohol: ☐ Never ☐ Previously ☐ Rarely ☐ Weekly ☐ Daily ☐ Other_____

Have you ever used tobacco: ☐ No ☐ Yes If yes, please answer the following questions:

Last used_____ Age use began _____ Total years of use_____ How many packs/day_____

Other substance use:

Name/Frequency:_____Last Used:_____

Name/Frequency:_____Last Used:_____

Name/Frequency:_____Last Used:_____

Reproductive History:

Have you ever had a menstrual period? ☐ No ☐ Yes If yes, Age of First Menstrual Period:_____ Last Menstrual Period:_____

Have you ever been pregnant? ☐ No ☐ Yes If yes, Number of Pregnancies:_____ Number of Live Births:_____

History of Breastfeeding? ☐ No ☐ Yes If yes, number of months:_____

Pre/Post-Menopausal? ☐ No ☐ Yes If yes, age of menopause:_____

Are you currently using contraceptives? ☐ No ☐ Yes If yes, which method:_____

Tubal Ligation? ☐ No ☐ Yes If yes, when:_____

Vasectomy? ☐ No ☐ Yes If yes, when:_____