CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

CASCADE MEDICAL CENTER
FAMILY PRACTICE CLINIC
ADULT HEALTH HISTORY

ALL INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL

Name	Birthdate	Today's Date
Job Title or Last Job Held	Current/Last Place of Employment	
Phone # (home) (work) (cell)		Single Married Widowed Other
Spouse (or partner)/children; names+ages:		

HEALTH CONCERNS

Please list briefly any major health concerns you would like evaluated, in order of significance.

PAST MEDICAL HISTORY

List any major illnesses (such as diabetes, heart disease, cancer, etc.), and give year problem happened or started.

Surgeries or major injuries (please list and give year).

Have you ever had a tuberculosis test? YES / NO If yes, please give approximate year: _____ Circle results of test: POSITIVE / NEGATIVE	Have you ever had a blood transfusion? YES / NO If yes, please give approximate year: _____

IMMUNIZATIONS

Please circle the immunizations you have received and give the most recent date.

Tetanus _____ Influenza (flu shot) _____ Pneumovax (pneumonia shot) _____

MEDICATION ALLERGIES

List any reactions you have had to medications (for example, penicillin or sulfa)

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FAMILY HISTORY & CURRENT HEALTH

MEDICATIONS (PRESCRIPTION and NON-PRESCRIPTION)

(Including vitamins, antacids, Tylenol, Ibuprofen (Motrin, Advil), aspirin, any herbal medications or remedies, etc.)

Please list those used regularly and dose taken.

FAMILY HISTORY

Have any family members (natural parents, siblings, grandparents) had any of the following problems?

(Please give age when problem began, if known)

ILLNESS	MOTHER	FATHER	SISTERS	BROTHERS	GRANDPARENTS
Diabetes					
Breast, prostate or colon cancer					
Heart disease or heart attack					
High blood pressure					
Stroke					
Alcoholism					
Osteoporosis (weak bones, hip fracture)					
Depression/Anxiety/Bipolar					
Gall Bladder/Kidney stones/Stomach Ulcer					
Other					

CURRENT HEALTH PRACTICES

Do you exercise regularly? YES / NO Type of exercise:

Do you drink alcohol? YES / NO If yes, what kinds? _____

On average, how much per day? _____ Per week? _____

Has anyone, including your family, ever said that drinking might be causing a problem for you? YES / NO

If yes, who was the person who made this comment?

Do you feel it is important to lose weight at this time? YES / NO

Circle the word which applies to your seatbelt use: ALWAYS SOMETIMES NEVER

Have you ever used tobacco products regularly? YES / NO If the answer is yes, please fill in the following:

Tobacco Product	Age Started	Duration of Use (years)	Average Amt. Per Day	Are you still using? YES / NO
				Date quit:

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REVIEW OF SYSTEMS
Please CIRCLE the items listed below with which you have had significant problems.

GENERAL		
Recent weight change	Significant fatigue	Always hot / Always cold
Rashes or skin problems	Night sweats / Hot flashes	New or changing skin moles or spots

EYE, EAR, NOSE and THROAT		
Brief loss of vision (ever)	Recent hearing change	Recent vision change
Teeth or gum problems	Any other problems with eyes, ears, nose or throat? YES / NO	

HEART and LUNGS		
Daily cough	Difficulty breathing while lying flat	Ankle swelling
Chest pain	Coughing up blood	Leg cramps while walking
Wheezing	Shortness of breath in day or night	

BREASTS	
Lumps / Any Skin Changes	Do you do monthly self breast exams? YES / NO
Drainage from nipple(s)	Month and year of last mammogram:

GASTROINTESTINAL		
Change of appetite	Diarrhea / Constipation	Difficulty swallowing
Blood in stool / Black stool	Heartburn	Abdominal pain
Nausea / Vomiting	Bloating / Gas	

GENITOURINARY (BOTH MEN and WOMEN)		
Difficulty starting urination	Urination more than twice a night	Leaking urine
Blood in urine	Painful urination	Pain or problems with intercourse
Do you have sexual interest in men / women / or both: (Please circle)		Sores in the genital area
Have you ever had any sexually transmitted disease (like chlamydia, gonorrhea, herpes, warts)? YES / NO		
Have had or are having difficulties with you sex life? YES / NO		

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GENITOURINARY (*WOMEN ONLY*)		
Change in menstrual pattern	Date of last menstrual period:	Number of children: Boys ___ Girls ___
Unusual vaginal discharge or itching	Frequency / Length of menstrual	Date of last pelvic exam:
Disabling menstrual cramps	periods:	Past history of abnormal pap smear:
		YES / NO If yes, date:

GENITOURINARY (*MEN ONLY*)	
Difficulty getting or keeping an erection	Pain or lump in testicles / scrotum

NEUROPSYCHIATRIC		
Frequent disabling headaches	Passing out	Frequent anxiety or anxiety attacks
Difficulty sleeping	Often feel sad or depressed	
Treated in past for emotional or psychological problems		

MUSCULOSKELETAL		
Frequent neck or back pain	Nightime leg cramps or “restless legs”	Muscle or joint problems

SOCIAL		
Recent significant changes in your life	Financial hardships	Dissatisfied with current employment
Special stresses in your life	In an abusive relationship (physical, sexual, verbal)	
Other concerns you wish to discuss:		