

Chehalis Clinic
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Chehalis, WA 98532
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www.hwnw.org



Longview Clinic
3331 Washington Way
Longview, WA 98632
360.578.2527 voice
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MEDICAL HISTORY

Patient Information

Last _____ First _____ M.I. _____

Birthdate ____/____/____ Age _____ Sex: Male Female

Family Medical History

Please list any significant family history of disease or illness, such as heart disease, stroke, cancer, etc.

Personal Medical History

1. Have you had any chronic or serious illness?
 Yes No

2. Do you have any history of infectious illness, such as HIV, Hepatitis or any other?
 Yes No
3. Have you had any operations? Yes No
If yes, list operation and the year performed.

4. Do you take any medications?
 Yes No
If yes, please list and explain.

5. Are you allergic to anything? Yes No
6. If yes, please list.

7. Has any health problem affected your ability to perform your current job? Yes No
8. Are you currently on any work restrictions?
 Yes No
9. Do you have a previous or currently open Labor & Industries claim? Yes No

Social History

1. Any past or present use of Tobacco?
 Yes No
2. Any past or present use of Illegal Drugs?
 Yes No
3. Any past or present use of Alcohol?
 Yes No
4. Any current intake of Caffeine?
 Yes No
5. Marital Status

6. Current Employer

7. Highest grade completed?

Reproductive History (Females)

1. Have you ever been pregnant?
 Yes No
2. If yes, how many times? _____
 - How many live births? _____
still births? _____ miscarriages? _____
surgical abortions? _____

Please indicate last known date:

Tetanus booster _____ Flu shot _____
Hepatitis A _____ Hepatitis B _____

Patient Signature

Reviewed by: _____