

Longview Clinic
3331 Washington Way
Longview, WA 98632
360.578.2527 voice
360.575.1460 fax
www.hwnw.org



Chehalis Clinic
1595 N National Ave #2
Chehalis, WA 98532
360.740.0444 voice
360.740.0704 fax
www.hwnw.org

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.

11. Do you have any current work restrictions?

Yes No

12. If yes, please explain.

Personal Medical History

1. Have you had any chronic or serious illness?

Yes No

2. If yes, please explain.

3. Have you had any operations? Yes No

4. If yes, list operation and your approximate age when performed.

5. Do you take any medications?

Yes No

6. If yes, please list and explain.

7. Are you allergic to anything? Yes No

8. If yes, please list.

9. Has any health problem affected your ability to perform your current job? Yes No

10. If yes, please explain.

Social History

1. Have you ever smoked cigarettes?

Yes No

2. Do you smoke cigarettes now?

Yes No

3. If you smoke cigarettes now or in the past, how many packs per day do/did you smoke?

4. If you smoke cigars, how many per day?

5. If you smoke a pipe, how many pipefuls do you smoke per day?

6. If you smoke, or did so previously, for how many years did you smoke?

7. If you have quit smoking, how long has it been since you stopped?

9. If you chew tobacco, how many cans per day?

10. Marital Status

11. Current Employer

12. Do you or have you used illegal drugs?

 If so, what was the drug(s) used?

13. Highest grade completed?

What is your approximate daily intake of the following?

1. Cups of coffee: _____ Cups of tea: _____
2. Bottles of beer: _____ glasses of wine _____
3. Ounces of liquor & type: _____

Check the appropriate box if you have had any of the following symptoms or problems:

SKIN, MUSCLE, JOINT

- | | |
|----------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Mole Changes | <input type="checkbox"/> Irritation/Itching |
| <input type="checkbox"/> Rashes, Dryness | <input type="checkbox"/> Back/Neck Pain |
| <input type="checkbox"/> Bone or Joint Pain/Swelling/Arthritis | <input type="checkbox"/> Fever/Night Sweats |
| <input type="checkbox"/> Joint or Back Stiffness | <input type="checkbox"/> Numbness/Tingling |
| | <input type="checkbox"/> Measles/Mumps/Rubella |

CHEST/ HEART & LUNGS

- | | |
|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Cough, Wheezing | <input type="checkbox"/> Leg Cramps |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swollen Feet |
| <input type="checkbox"/> Rapid Heartbeat | <input type="checkbox"/> Breast Lump or Pain |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Nipple Discharge |
| <input type="checkbox"/> Chest Pain/Tightness | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Bronchitis/pneumonia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma |

DIGESTION

- | | |
|-------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Bloating/Gas |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Blood in Stool |
| <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Black Stool |
| <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Gallbladder disease |
| | <input type="checkbox"/> Hemorrhoids |

HEAD & NECK

- | | |
|---------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing Changes |
| <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Trouble Swallowing |
| <input type="checkbox"/> Hay Fever, Sinus Trouble | <input type="checkbox"/> Hoarseness/Change in Voice |
| <input type="checkbox"/> Eye Pain/Redness | <input type="checkbox"/> Ear Problem |
| <input type="checkbox"/> Teeth/Gum Problem | <input type="checkbox"/> Vision defects |

KIDNEYS & BLADDER

- | | |
|--------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Change in Stream |
| <input type="checkbox"/> Urgency/Pain | <input type="checkbox"/> Start/Stop Difficulty |
| <input type="checkbox"/> Prostate Trouble | <input type="checkbox"/> Testicle Lump or Tenderness |
| <input type="checkbox"/> Sexual Difficulty | |
| <input type="checkbox"/> Kidney Stone | |

NERVOUS SYSTEM

- | | |
|--------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of Coordination |
| <input type="checkbox"/> Change in Touch | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety or Irritability | <input type="checkbox"/> Hand Tremor |

GYNECOLOGIC (FEMALES)

- | | |
|-------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Painful Menstruation |
| <input type="checkbox"/> Severe Cramps | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Irregular Menstruation | |

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? _____

Other Conditions: please mark if yes:

- | | |
|--------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Positive TB Test | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Weakness, Fatigue | |

Please indicate last known date:

Tetanus booster _____ Flu shot _____
 Hepatitis A _____ Hepatitis B _____
 MMR _____ Chicken Pox _____

Additional Comments: _____

Patient Signature _____

Reviewed by: _____