bmc Total Care™
Bend Memorial Clinic P.C.

Name_____

Date of Birth_____ Today's Date_____

Adult Health History Form

Your answers on this form will help your health care provider to better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!

Reason(s) for today's visit: _____

Race: ❑ American Indian ❑ Asian ❑ Black/African ❑ Caucasian/White ❑ Hispanic ❑ Native Hawaiian Pacific Islander ❑ Not Listed/Reported ❑ Unknown ❑ Declined to Report

Ethnicity: ❑ Non-Hispanic ❑ Unreported ❑ Decline Preferred Language _____

Have you completed an advanced health care directive? ❑ Yes ❑ No

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
__ Recent fevers/sweats
__ Unexplained weight loss/gain
__ Unexplained fatigue/weakness

Gastrointestinal
__ Heartburn/reflux
__ Blood or change in bowel movement
__ Nausea/vomiting/diarrhea
__ Pain in abdomen

Psychiatric
__ Anxiety/stress
__ Sleep problem

Blood/Lymphatic
__ Unexplained lumps
__ Easy bruising/bleeding

Breast
__ Breast lump
__ Nipple discharge

Respiratory
__ Cough/wheeze
__ Coughing up blood

Cardiovascular
__ Chest pains/discomfort
__ Palpitations
__ Short of breath with activity

Genitourinary
__ Painful/bloody urination
__ Leaking urine/Night time urination
__ Concern with sexual functions
__ Discharge: penis or vagina
__ Unusual vaginal bleeding

Musculoskeletal
__ Muscle/joint pain
__ Recent back pain

Skin
__ Rash
__ New or change in mole

Eyes
__ Change in vision

Ears/Nose/Throat/Mouth
__ Difficulty hearing/ringing in ears
__ Hay fever/allergies/congestion
__ Trouble swallowing

Neurological
__ Headaches
__ Memory loss
__ Fainting

Endocrine
__ Cold/heat intolerance
__ Increase thirst/appetite

In the past month, have you experienced a lack of interest/pleasure in activities, felt down, depressed or hopeless? ❑ Yes ❑ No

MEDICATIONS: Prescription/non-prescription, vitamins, home remedies, birth control pills, herbs, etc.

Medication Name	Dosage(mg/pill)	Times per Day

Allergies or reactions to medications:_____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol): _____	Date_____	Abnormal? ❑ Yes ❑ No
Men: PSA (Prostate)	Date_____	Abnormal? ❑ Yes ❑ No
Sigmoidoscopy or Colonoscopy	Date_____	Abnormal? ❑ Yes ❑ No
Women: Mammogram	Date_____	Abnormal? ❑ Yes ❑ No
Pap Smear	Date_____	Abnormal? ❑ Yes ❑ No
Dexascan (osteoporosis)	Date_____	Abnormal? ❑ Yes ❑ No

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems

❑ Heart disease: ❑ High blood pressure
specify type _____
❑ Asthma/Lung disease
❑ Other: (specify): _____
❑ High cholesterol ❑ Kidney disease
❑ Diabetes ❑ Thyroid problem
❑ Cancer: (specify): _____

SURGICAL HISTORY: Please list all prior operations (with dates):

_____

_____

_____

FAMILY HISTORY: Please indicate family members who have or have had any of the following:
(Parent, Grandparent, Sibling, Other)

Alcoholism_____
Diabetes_____
Heart disease_____
Depression/suicide _____
Genetic disorders _____
Cancer (specify) _____
High cholesterol _____
High blood pressure_____
Stroke_____
Bleeding/clotting disorder _____
Asthma/COPD _____
Other: _____

SOCIAL HISTORY:

Tobacco Use:
❑ Never Quit Date _____
❑ Want to quit? _____
❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew ❑ Cigarettes

Alcohol/Drug Use: # drinks/week _____
Is your alcohol use a concern for you or others?
❑ Yes ❑ No
Recreational Drug Use: ❑ Yes ❑ No

Sexual Activity:
Sexually active: ❑ Yes ❑ No ❑ Not currently
Current sex partner(s) is/are: ❑ male ❑ female
Birth control Birth control method: _____ None needed
Have you ever had a sexually transmitted disease (STD)?
❑ Yes ❑ No
Are you interested in being screened for sexually transmitted disease? ❑ Yes ❑ No

Women's Health History:
#pregnancies_____
#deliveries _____ #abortions _____ #miscarriages _____
Age period started _____
Date of last period _____ Age period ended_____

Caffeine Intake:
Coffee/tea/soda _____ cups/day
❑ None

Weight: Are you satisfied with your weight?
❑ Yes ❑ No

Diet: How do you rate your diet?
❑ Good ❑ Fair ❑ Poor
Do you eat or drink four servings of dairy or soy daily or take calcium supplements? ❑ Yes ❑ No

Exercise: Do you exercise regularly? ❑ Yes ❑ No
What kind of exercise? _____
How long (minutes) _____How often? _____
If you do not exercise, why not? _____
_____

Safety: Do you use a bike helmet? ❑ Yes ❑ No
Do you use seatbelts consistently? ❑ Yes ❑ No
Have you ever been abused? ❑ Yes ❑ No
Do you have a gun in your home? ❑ Yes ❑ No
Is violence at home a concern? ❑ Yes ❑ No

ADL, can you:
Dress yourself? ❑ Yes ❑ No ❑ With Assistance
Make your own meals? ❑ Yes ❑ No ❑ With Assistance
Do your own shopping? ❑ Yes ❑ No ❑ With Assistance

Socioeconomics:
Occupation:_____ Employer:_____ Highest level of Education _____
❑ Marital Status: ❑ Single ❑ Partner/Married ❑ Divorced ❑ Widowed ❑ Other: _____
Spouse/partner's name: _____
Number of children/ages: _____ Who lives at home with you? _____