Print Form

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Lane Community College Health Clinic
4000 East 30th Ave., Eugene, OR 97405, Phone (541) 463-5665

PERSONAL HEALTH HISTORY

Name _____ Date of Birth _____
Last First Middle
L #_____

HEALTH REVIEW

Height _____ Weight _____

ALLERGIES TO MEDICATIONS _____

ALLERGIES - OTHER _____

No known allergies [ ]

Current medications _____

Smoking/Chewing: Never [ ]; Quit [ ] If quit, when? _____; Yes [ ]; If yes, how many (much) per day? _____

Do you exercise regularly? Yes [ ] No [ ]; If yes, type of exercise and how often _____

Have you had your cholesterol measured? Yes [ ] No [ ]; If yes, result _____

HAVE YOU EVER HAD A PROBLEM WITH :

YES	NO		YES	NO	
[ ]	[ ]	Alcohol/Drugs	[ ]	[ ]	Mononucleosis (mono) or Infectious Mono
[ ]	[ ]	Anemia/Sickle Cell Anemia	[ ]	[ ]	Orthopedic Problem (e.g.,knee, back)
[ ]	[ ]	Anorexia/Bulimia/Eating Problems	[ ]	[ ]	Prolonged Depression or Anxiety
[ ]	[ ]	Asthma	[ ]	[ ]	Speech, Hearing, or Vision Problem
[ ]	[ ]	Bronchitis or Pneumonia	[ ]	[ ]	Sexually Transmitted Diseases
[ ]	[ ]	Cancer	[ ]	[ ]	Chlamydia
[ ]	[ ]	Convulsions, Seizures (epilepsy)	[ ]	[ ]	Gonorrhea
[ ]	[ ]	Diabetes	[ ]	[ ]	Genital Warts
[ ]	[ ]	Digestive Tract Disease (e.g., ulcer, colitis)	[ ]	[ ]	Herpes
[ ]	[ ]	Gallbladder/Liver Disease/Hepatitis	[ ]	[ ]	Syphilis
[ ]	[ ]	Hay Fever	[ ]	[ ]	Sinusitis
[ ]	[ ]	Headaches (severe)	[ ]	[ ]	Skin Disease (e.g., eczema, psoriasis)
[ ]	[ ]	Head Injury	[ ]	[ ]	Stroke
[ ]	[ ]	Heart Disease (rheumatic fever, murmur)	[ ]	[ ]	Thrombophlebitis
[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Thyroid or Endocrine Abnormalities
[ ]	[ ]	HIV Infection	[ ]	[ ]	Tuberculosis
[ ]	[ ]	Kidney Disease or Urinary Tract Infection	[ ]	[ ]	Other altered abilities _____

Please comment on any "yes" answers listed above _____

Have you ever been hospitalized? Yes [ ] No [ ]

If yes, date(s) _____ Reason _____

Dates and types of surgery _____

I am currently under treatment for _____

Any other health needs or concerns _____

IMMUNIZATIONS - Indicate dates if known, otherwise check (Y) if you know you have received them.

Measles, Mumps, and Rubella (MMR) _____ _____

Hepatitis B _____ _____ _____

Hepatitis A _____ _____

Tetanus/Diphtheria (Td) _____

Last Tuberculin Skin Test Date _____ Result _____

FAMILY HISTORY

If any member of your immediate family (parents, grandparents, siblings, or children) has any of the following, please indicate which family member:

_____	Alcoholism	_____	Hepatitis/Yellow Jaundice	_____	Stroke
_____	Cancer (breast, colon)	_____	High Blood Pressure	_____	Tuberculosis
_____	Diabetes	_____	Kidney Disease	_____	Thyroid Disease
_____	Heart Disease	_____	Mental Illness/Suicide		

Any other significant family problems?

_____

PLEASE CONTINUE
The following questions are optional; however, the information will help us to better serve you.

CONTRACEPTIVE HISTORY

Have you ever had intercourse? _____ Age at first intercourse _____ Are you sexually active now? _____

Do you use a birth control method now? If yes, what? _____

If no, would you like birth control information today? _____; Do you wish to continue your present method? _____

List all birth control methods used:

METHOD (name of Pill / IUD, etc.)	DATES USED	PROBLEMS
_____	_____	_____
_____	_____	_____

LIFE SITUATIONS

These questions assist us in providing you with optimal care. **All information is strictly confidential. Answering is optional.**

Yes ☐ **No** ☐ Do you drink alcohol? Average drinks per week _____
Yes ☐ **No** ☐ Do you use recreational drugs? What type _____ How often _____
Yes ☐ **No** ☐ Were you ever assaulted in your home?
Yes ☐ **No** ☐ Are you afraid of someone you live with?
Yes ☐ **No** ☐ Are you presently sexually active now?
#_____ Number of NEW sexual partners in the last six months?
M ☐ **F** ☐ **Both** ☐ What gender have your sexual partners been?
Yes ☐ **No** ☐ Do you have any questions or problems related to sex?

WOMEN'S CLINIC HISTORY

MENSTRUAL HISTORY

Periods began at age _____ ; First day of most recent period _____/_____/_____; Was that period normal? Yes ☐ No ☐

Cycle lasts _____ days. (First day of your period until the first day of your next period.)

Menstrual flow lasts _____ days. Menstrual flow is: Light ☐ Moderate ☐ Heavy ☐

Cramping? None ☐ Mild ☐ Moderate ☐ Severe ☐

If using Pill / IUD now, were your periods different before you used them ? Yes ☐ No ☐ If yes describe _____

Have you ever had a pelvic exam? Yes ☐ No ☐; Date of last exam _____; Pap: Normal ☐ Abnormal ☐

Describe any unusual bleeding pattern _____

If you were born before **1972**, did your mother take the medicine DES while pregnant with you? N/A ☐ Yes ☐ No ☐ Don't know ☐

PREGNANCIES

Have you ever been pregnant? _____ Age at first pregnancy _____ Do you think you might be pregnant now? _____

Number of	_____ Pregnancies	_____
	_____ Miscarriages	_____
	_____ Stillbirths	_____
	_____ Abortions	_____
	_____ Live births	_____

Have you ever had an ectopic (tubal) pregnancy or premature birth? Yes ☐ No ☐

Breastfeeding now? Yes ☐ No ☐

High blood pressure during pregnancy? Yes ☐ No ☐; Other complication of pregnancy? _____

Genetic disorders in your family or your children? _____; Do you want to become pregnant in the future _____

The Health Clinic provides diagnosis and treatment for uncomplicated medical problems during routine clinic hours. No after-hours coverage is provided. I hereby consent to all treatments, diagnostic procedures, all or any of which is deemed necessary or advisable by the doctor, the doctor's associates, or assistants.

_____ _____

Signature ***Date***

The information on this form is confidential and will be released only with your written authority or a subpoena issued by the court. The purpose of this questionnaire is to provide information to aid Health Clinic practitioners with your continued medical care, both in emergency and routine situations.