HEALTH HISTORY ASSESSMENT

Eastern Oregon University | Student Health Center
One University Blvd., La Grande, Oregon 97850
Phone: 541-962-3524 Fax: 541-962-3825

Patient Name: _____ Date: _____
Medications: List any medicines you take regularly, including over the counter medications or supplements

_____

_____

_____

Allergies: Medications Yes No Please list _____
Other: latex, food, insects etc.: Yes No Please list _____

FAMILY MEDICAL HISTORY

Please circle yes if any IMMEDIATE family members(even if deceased) have or had any of the following:
_____ No Family History Problems Known

Adverse reaction to anesthesia	Mother	Father	Brother	Sister	_____
Arthritis	Mother	Father	Brother	Sister	_____
Cancer	Mother	Father	Brother	Sister	_____
Diabetes	Mother	Father	Brother	Sister	_____
Heart Problems	Mother	Father	Brother	Sister	_____
Bleeding or Clotting Problems	Mother	Father	Brother	Sister	_____
Melanoma	Mother	Father	Brother	Sister	_____
Tuberculosis	Mother	Father	Brother	Sister	_____
Substance Abuse	Mother	Father	Brother	Sister	_____
Other	Mother	Father	Brother	Sister	_____

SURGICAL and HOSPITALIZATION HISTORY

Indicate any major surgeries and dates of surgery (if you choose OTHER please describe):
_____ No Surgery _____No hospitalizations

Eyes	( ) Cataract _____ ( ) Lasik Surgery _____ ( ) Tear Duct _____ ( ) Other _____
Ears	( ) Tubes _____ ( ) Eardrum _____ ( ) Mastoid _____ ( ) Other _____
Nose	( ) Septoplasty _____ ( ) Rhinoplasty _____ ( ) Sinus Surgery _____ ( ) Other _____
Throat/neck	( ) Adenoidectomy _____ ( ) Tonsillectomy _____ ( ) Thyroidectomy _____
Heart	( ) Angioplasty _____ ( ) Bypass _____ ( ) Valve _____ ( ) Stent _____ ( ) Other _____
Digestive	( ) Appendectomy _____ ( ) Gallbladder _____ ( ) Hiatal Hernia _____ ( ) Other _____
Female Health	( ) Uterine _____ ( ) Ovary _____ ( ) Cervix _____ ( ) Other _____
Male Health	( ) Testicle _____ ( ) Prostate _____ ( ) Other _____
Musculoskeletal	( ) Joint _____ ( ) Fracture _____ ( ) Ligamentn _____ ( ) Tendon _____ ( ) Other _____
Other	( ) Head Injury _____ ( ) Motor Vehicle Accident _____ ( ) Any other major surgery _____

Please List any Hospital Admissions other than above: _____

_____

_____

IMMUNIZATION HISTORY (not required for entry)

> Varicella (Chicken Pox) Date 1st dose ___/___/___ Date 2nd dose ___/___/___
OR Chickenpox disease date ___/___/___

> Tetanus Booster Date ___/___/___ Did it contain Pertussis? Yes/ No/Unknown

> Gardasil (HPV) Date 1st dose ___/___/___ Date 2nd dose ___/___/___ Date 3rd dose ___/___/___

> Hepatitis B Date 1st dose ___/___/___ Date 2nd dose ___/___/___ Date 3rd dose ___/___/___

> Hepatitis A Date 1st dose ___/___/___ Date 2nd dose ___/___/___ Meningococcal ___/___/___

PATIENT MEDICAL HISTORY

Patient Name: _____ Date: _____

Birthdate _____

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING? (Circle YES or NO)

CARDIOVASCULAR

High Blood pressure	Yes	No
Cardiac Disease	Yes	No
Heart Valve Conditions/Replacement	Yes	No
Murmur	Yes	No
Pacemaker	Yes	No
Varicose Veins	Yes	No

DERMATOLOGIC

Acne	Yes	No
Eczema	Yes	No
Excessive Scarring	Yes	No
Hair Loss	Yes	No
Nail Problems	Yes	No
Skin Cancer	Yes	No
Recurrent or Chronic Skin Infections	Yes	No

ENDOCRINE

Diabetes	Yes	No
Thyroid problems	Yes	No

GASTROINTESTINAL

Difficulty Swallowing	Yes	No
Liver Conditions	Yes	No
GERD / Ulcer	Yes	No

GU/RENAL

Dialysis	Yes	No
Kidney Disease	Yes	No

FEMALE REPRODUCTIVE

Excessive Bleeding	Yes	No
Irregular Menstrual Cycles	Yes	No
Miscarriages	Yes	No
Pregnancy	Yes	No
Breast Cancer / Breast Lumps	Yes	No

MALE REPRODUCTIVE

Testicular Cancer / Testicular Lumps	Yes	No
Difficulty Obtaining / Sustaining Erections	Yes	No

HEENT

Glaucoma	Yes	No
Sinus Conditions	Yes	No
Frequent or Chronic Ear/Throat Infections	Yes	No

HEMATOLOGIC

Anemia	Yes	No
Bone Marrow Cancer	Yes	No
Bruise or Bleed Easily	Yes	No
Leukemia or Lymphoma	Yes	No
Low Platelets	Yes	No
Low White Blood Cells	Yes	No
Blood Clots	Yes	No

IMMUNOLOGIC

Hepatitis B or C	Yes	No
Herpes	Yes	No
HIV/AIDS	Yes	No
Tuberculosis	Yes	No

MUSCULOSKELETAL

Arthritis Condition	Yes	No
Gout	Yes	No
Joint Pain	Yes	No
Lupus	Yes	No
Traumatic Injury	Yes	No

NEUROLOGIC

Fainting	Yes	No
Headaches	Yes	No
Seizure Disorders	Yes	No

PSYCHIATRIC

Anxiety Disorder	Yes	No
Chemical Dependency	Yes	No
Depression	Yes	No
Eating Disorders	Yes	No
Phobia	Yes	No

RESPIRATORY

Abnormal Chest X-ray	Yes	No
Asthma	Yes	No
Bronchitis / Pneumonia	Yes	No
Lung Cancer	Yes	No
Shortness of Breath	Yes	No

OTHER: _____

Please explain any 'Yes' answers here: _____