

# WEST LINN FAMILY HEALTH CENTER, P.C.

18380 WILLAMETTE DRIVE, SUITE 202 - WEST LINN, OREGON 97068-1718 - PHONE (503) 635-8384 - FAX (503) 636-6475

## CONFIDENTIAL HEALTH HISTORY FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date Completed \_\_\_\_\_

**Current and Major Illnesses** (ie high blood pressure, cholesterol, pneumonia, etc)

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**Prescription medications** (please include frequency and strength if known):

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**Over the counter medications and supplements:**

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**Previous surgeries/complications:**

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**List any allergies** (please include medications)

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**Family history of disease** (ie diabetes, heart disease, cholesterol, high blood pressure, cancer) Please be as specific as possible:

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**Alcohol use** (please circle): Yes No  
If yes, how frequently: Daily Weekly Occasional  
How many beverages on average: 1-2 3-4 5+

**Tobacco use** (please circle): Yes No  
If yes, type: Cigarettes Cigars Smokeless

**Marital status** (please circle): Single Married Widowed Significant Other

**Children** (please circle): Yes No  
If yes how many and ages: \_\_\_\_\_

**Exercise** (please circle): None 1-2days per week 3-4days per week 5+days per week

### Women Only:

Age periods began \_\_\_\_\_ Frequency \_\_\_\_\_

Date of last period \_\_\_\_\_

Excessive bleeding? \_\_\_\_\_

Do you take hormone or birth control pills? \_\_\_\_\_

Pregnancies \_\_\_\_\_ How many children? \_\_\_\_\_ Miscarriages \_\_\_\_\_