Oregon Rheumatology Specialists
A Practice of Oregon Specialty Group

Patient History Form

Today's Date: _____ Patient Name: _____ Date of Birth: _____ Age: _____ Referring Provider: _____ Primary Care Provider: _____ Language Preferred: _____	Gender: ☐ Male ☐ Female ☐ Non-Binary Other: _____ Preferred Pronouns: _____
Chief Complaint: What is your understanding of why you are being seen here today? _____	

FAMILY HISTORY

My father is: ☐ Alive or ☐ Deceased Cause of death: _____

My mother is: ☐ Alive or ☐ Deceased Cause of death: _____

Please list health problems that run in your family: _____

_____

_____

_____

HABITS

Do you use tobacco products? ☐ No ☐ Yes – ☐ Cigarettes ☐ Chewing tobacco ☐ Other: _____

If you use tobacco products, how much do you use per day (packs, cigarettes, etc.)? _____

How long have you been using tobacco products? _____

Have you used tobacco in the past? ☐ No ☐ Yes If stopped, when? _____

Do you drink alcohol? ☐ No ☐ Yes - Number of drinks: ____ per ☐ day ☐ week ☐ month

Did you drink heavily in the past? ☐ No ☐ Yes

Do you use illicit drugs? ☐ No ☐ Yes – What type? _____

How do you use drugs? ☐ IV ☐ Inhalants ☐ Smoking How often? _____

Do you use marijuana? ☐ No ☐ Yes – How do you use marijuana? ☐ Edibles ☐ Oils/Tinctures ☐ Inhalants

Do you have a history of drug use? ☐ No ☐ Yes – Provide details below, including what type, how often, and how you used drugs:

_____

_____

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MEDICATIONS

I will bring a copy of my medication list to my first appointment ☐ No ☐ Yes (If no, please list all below)

Name of Drug	Dose	Frequency	Name of Drug	Dose	Frequency

Preferred Pharmacy: _____

Allergies:

Are you allergic to any medications, vaccines, contrast dye, latex, or adhesives? ☐ No ☐ Yes

I will bring a copy of my list of allergies to my first appointment ☐ No ☐ Yes (If no, please list all below)

Allergies: _____

VITAMINS & SUPPLEMENTS

I will bring a copy of my list of vitamins & supplements to my first appointment ☐ No ☐ Yes (If no, please list all below)

Vitamin or Supplement Name	Dose	Frequency	I am taking for:

PAST AND PRESENT MEDICAL CONDITIONS: Check all that apply

☐ Allergies
☐ Angina
☐ Anxiety
☐ Asthma
☐ Arthritis
☐ Bladder Infections
☐ Blood Clots
☐ Blood Transfusion
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ COPD
☐ Diabetes
☐ Depression
☐ Emphysema
☐ Gallstones
☐ Glaucoma
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Irregular Heartrate
☐ Irritable Bowel
☐ Kidney Infections
☐ Low Back Problems
☐ Migraine Headaches
☐ Panic Attacks
☐ Peripheral Vascular Disease
☐ Phlebitis
☐ Pneumonia
☐ Prostate Trouble
☐ Seizures
☐ Sickle Cell Anemia
☐ Sinus Trouble
☐ Skin Cancer
☐ STD's
☐ Stomach Ulcers
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Urinary Tract Infections

Past Operations
☐ Tonsils
☐ Gallbladder
☐ Appendix
☐ Hysterectomy
☐ Prostate
☐ Hernia
☐ Heart
☐ Breast
☐ Tubal Ligation
☐ Vasectomy
☐ Other: _____