OHSUHealth
Hillsboro Medical Center

Hillsboro Medical Center Interventional Radiology
333 SE 7th Ave Ste 520
Hillsboro, OR 97123

Patient Health History

What is the reason for today's visit?

____

____

____

Medical history

Do you have, or have you had, any of the following problems? Let us know the date if you don't have the problem now.

Medical condition	Yes	No	Date
Diabetes			
High blood pressure			
Heart attack			
Dialysis			
Cancer			
Other:			

List any surgeries you have had and any time you were in the hospital.

Surgery or reason in hospital	Date	Complications, if there were any

Have ever had problems with anesthesia (being put under)? ☐ Yes ☐ No

List any medications you are currently taking. Please include how much and how often.

Medication	How much (dose)	How often (frequency)

What are you allergic to?

____

____

____

What is your family history?

Family member	Alive?	Age or age at death	Health status or cause of death
Grandmother (mom's side)	☐ Yes ☐ No		
Grandmother (dad's side)	☐ Yes ☐ No		
Grandfather (mom's side)	☐ Yes ☐ No		
Grandfather (dad's side)	☐ Yes ☐ No		
Mother	☐ Yes ☐ No		
Father	☐ Yes ☐ No		
☐ Sister ☐ Brother	☐ Yes ☐ No		
☐ Sister ☐ Brother	☐ Yes ☐ No		
☐ Sister ☐ Brother	☐ Yes ☐ No		
☐ Sister ☐ Brother	☐ Yes ☐ No		

Social history

What do you do for a living? ____

Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Do you have children? ☐ Yes ☐ No How many? ______________________________

Do you live alone? ☐ Yes ☐ No Who lives with you? ______________________________________

Do you smoke?

☐ Yes, I've smoked _________ packs of cigarettes a day for _________ years.

☐ Yes, I smoke a cigar or pipe.

☐ No, I have never smoked.

☐ No, I quit _______ years ago. Before that, I smoked _______ packs a day for _______ years.

Do you drink alcohol?

☐ Never or rarely ☐ No, but I used to

☐ Yes, daily ☐ Yes, 1+ times per week ☐ Yes, 1+ times per month

Additional medical history

Do you have, or have you had problems with any of the following?

Medical condition	Yes	No
General		
Fever		
Sudden weight loss		
Extreme tiredness (fatigue)		
Eyes		
Wear glasses – the date of my last exam: _______________		
Injuries		
Glaucoma		
Ear, Nose, Throat and Mouth		
Wear hearing aids – the date of my last exam: _______________		
Hearing loss		
Nosebleeds		
Sinus problems		
Sinus headaches		
Mouth sores		
Heart and vascular		
Chest pain or angina – the date of my last EKG: _______________		
Irregular pulse		
Heart murmur		
High cholesterol		
Swelling in feet or hands		
Leg pain while walking		

Medical condition	Yes	No
Breathing		
Asthma		
Long-lasting (chronic) cough		
Emphysema		
Shortness of breath		
Date of my last chest x-ray: _______________		
Digestion		
Heartburn (indigestion) or pain when eating		
Feeling like you want to throw up (nausea)		
Liver disease		
Stomach pain		
Blood in your stool (feces)		
Changes in your bowel habits		
Ulcers or gastritis		
Genital and urinary		
Abnormal pap smears – if yes, how treated: ________________________		
Urinary tract infections (UTIs)		
Blood in your urine		
Loss of bladder control (incontinence)		
Kidney stones		
Bone and joint		
Broken bones – list: ____		
Back pain		
Joint pain or swelling		
Arthritis		
Skin		
Eczema		
Psoriasis		
Neurological		
Fainting (blacking out)		
Seizures		
Memory problems		
Trouble speaking		
Double or blurred vision		
Psychiatric		
Anxiety		
Depression		
Other condition or treatment: _____________________________________		

Medical condition	Yes	No
Endocrine		
Increased appetite		
Too much thirst or urination		
Hormone problems		
Blood and lymph glands		
Anemia		
Bleeding easily		
Long-lasting swollen glands or lymph nodes		
Blood transfusion – the date of my last transfusion: _______________		
Allergies		
Food allergies		
Nasal allergies (pollens, molds, dust mites, pet dander, etc.)		

Patient Signature: ____ Date: ________________________

Patient Name: ____