DESCHUTES RIM
HEALTH CLINIC

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ADULT MEDICAL HISTORY FORM

Patient Name _____ Date of Birth _____ Today's Date _____

Medical Conditions: Please list all past and current health problems you have experienced. If you no longer have the condition, mark **P** for Past. If you still deal with the condition, take medication for it, or see a specialist regularly to monitor it, mark **C** for Current.

PROBLEM	YEAR STARTED	PAST (**P**) OR CURRENT (**C**)?

Allergies: Please list any allergies to medications, iodine, shellfish, tape, or latex.

☐ NO KNOWN ALLERGIES

ALLERGY	TYPE OF REACTION

Medications: Please list all prescription and over-the-counter medications you use, including eye drops, inhalers, vitamins and herbal supplements. Write down dose and how you take it as well (once a day, twice a day, etc.)

Surgical History: Please list any major surgeries you have had, and the approximate year that you had the procedure.

PROCEDURE	YEAR

Family History: Please list any serious health problems that your biologic relatives have experienced, such as cancer, diabetes, depression, etc. Please indicate which of your relatives have the condition and how old they were at the time of diagnosis, if you know.

CONDITION	FAMILY MEMBER	AGE

Preventative Health History:

Screening Tests:

TEST	YEAR DONE
Colon Cancer Screening: Please circle any of the tests you have had for this screening Colonoscopy Cologuard stool DNA FIT stool blood cfDNA Blood Test (such as ColonSentry)	
Breast Cancer Screening: Mammogram	
Cervical Cancer Screening: Pap Smear	
Osteoporosis Screening: Bone density (DEXA) scan	
Cholesterol blood test	
Hepatitis C virus (HCV) Infection	
Human Immunodeficiency Virus (HIV) Infection	

Immunizations:

VACCINE	YEAR(S) DONE
Pneumonia (Prevnar 13, Prevnar 20, Pneumococcal 23)	
Tetanus-Pertussis (Adacel, Boostrix)	
Shingles (Shingrix, Zostavax)	
RSV (Arexvy, Abrysvo)	
COVID-19	
Hepatitis B virus	
Human papilloma virus	

Health Risk Questions:

In the past 2 weeks, have you felt down, depressed or hopeless?	☐ No	☐ Yes
In the past 2 weeks, have you lost interest in activities?	☐ No	☐ Yes
How many times in the last year have you taken >4 alcoholic drinks in 1 day if you are a woman, or >5 drinks in 1 day if you are a man?	☐ Never	☐ At least once
In the past year have you used a recreational drug, or a prescription drug for non-medical reasons?	☐ No	☐ At least once
Do you use tobacco?	☐ No	☐ Yes
Have you used tobacco in the past?	☐ No	☐ Yes
If yes, when did you quit?		

Advance Directives:
Do you have an Advanced Directive?

☐ Yes Please Specify: ☐ Living Will ☐ Durable Power of Attorney for Health ☐ Other:_____

☐ No If no, would you like information about Advanced Directives today? ☐ No ☐ Yes

Additional Health History:

Please use this area for extra space, or for additional information not listed elsewhere on this form that you would like your health care team to know about you.