PO Box 397 ● 450 Tatone Street, Boardman, OR 97818 ● 541-481-7212 ● www.crhclinic.net

PATIENT INFORMATION SHEET

TODAYS DATE____/____/____

LAST NAME_____________________________ M.I._____ FIRST NAME________________________ DOB ____/____/______

HOME ADDRESS____ CITY_________________STATE______ZIP__________

MAILING ADDRESS_______________________________________ CITY_________________ STATE_______ ZIP_________

HOME PHONE_(_____)________________ ALT. PHONE_(_____)_______________ WORK PHONE_(_____)________________

GENDER _____________________ MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
OCCUPATION_____________________________

PATIENT GUARDIAN/REPRESENTATIVE (if applicable) ______________________ RELATION TO PATIENT_____________

DO YOU HAVE ALLERGIES TO LATEX? **Y / N**

PLEASE LIST ALL MEDICATION ALLERGIES ____

____

EMERGENCY CONTACT_______________________________________ PHONE NUMBER_____________________________

RELIGIOUS AFFILIATION ______________________ MILITARY SERVICE? **Y / N** YEARS OF EDUCATION __________

PLEASE LIST ANY OTHER ALLERGIES (Environmental/Foods) ____

LIST ALL **MEDICATIONS** YOU TAKE BELOW (Prescription/Non-prescription)
(include herbal remedies, vitamins, and other supplements)

☐ **I do not take any medications**

DRUG NAME/STRENGTH	DOSAGE	DRUG NAME/STRENGTH	DOSAGE

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Preferred Pharmacy ______________________________ Phone ___________________________ Fax ______________________

Address ____ City ________________________ State ________ Zip____________

PAST MEDICAL HISTORY (PLEASE CHECK ALL YOU HAVE OR HAVE HAD)

☐ Heart Disease ☐ Heart murmur ☐ High Blood Pressure ☐ Heart Attack ☐ Stroke ☐ High Cholesterol	☐ Cancer (type)________________ ☐ Hypothyroidism ☐ Diabetes ☐ Kidney Disease ☐ Kidney stone(s) ☐ Anemia ☐ Goiter	☐ Epilepsy ☐ Arthritis (type)______________ ☐ HIV/AIDS ☐ Cataracts ☐ Skin disease ☐ Anxiety ☐ Depression
☐ Asthma ☐ COPD ☐ Pneumonia ☐ Tuberculosis ☐ Pulmonary Embolism ☐ Rheumatic Fever ☐ Seasonal Allergies	☐ Hepatitis ☐ Jaundice ☐ Stomach ulcer ☐ Colitis ☐ Crohn's Disease ☐ Pancreatitis	Other medical conditions (please list): ________________________________ ________________________________ ________________________________ ________________________________

Last Menstrual Period	Yes / No Date:__________	Normal Abnormal
Colonoscopy	Yes / No Date:_________	Normal Abnormal
Mammogram	Yes / No Date:__________	Normal Abnormal
DXA (Bone Density)	Yes / No Date: __________	Normal Abnormal
PAP Smear	Yes / No Date:_________	Normal Abnormal

Have you had a hysterectomy? **Y / N**
If yes: (Complete or Partial) Date: _________________________
Reason: ____

Do you smoke tobacco? **Y / N** Chew tobacco? **Y / N**
If yes, how much/how long? ______________________________
Drink alcohol? **Y / N** If yes, how much? ___________________
Any other drug use? **Y / N** If yes, list: ______________________
Coffee? **Y / N** If yes, how much? __________________________

Have you ever been hospitalized? **Y / N**
If yes, list date(s) and reason(s):
____
____
____

FAMILY HISTORY

	AGE	HEALTH / MEDICAL CONDITIONS	CAUSE OF DEATH
Father (Alive / Deceased)			
Mother (Alive / Deceased)			

Other pertinent family history ____
____

Last Revised: 11/27/17

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SURGICAL HISTORY (List type, reason and date of previous surgeries)

SURGERY/REASON (if applicable)	Date	SURGERY/REASON (if applicable)	Date

List other medical providers you use on a regular basis (i.e. Cardiologist, Mental health, Kidney, OB/GYN, Cancer, etc.)

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