



Health History

Patient Name: _____ Date of Birth: _____

Who was your last primary care provider? _____

Please list other Health Care Providers or Specialists you are currently seeing as a patient:

Are there any problems you specifically want to address?

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR THE FOLLOWING

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Esophageal/GERD | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Angina/Heart Attack | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Excessive Snoring/Sleep Apnea | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Deaf/Hearing Issues | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Painful Menses |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dementia | <input type="checkbox"/> Heart Valve Problems | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Clots Location: _____ | | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Blind/Vision Issues | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Cancer Type: _____ | | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) | |

Other health problems:



Jon E. L. Ermshar, MD | Brett Rasmussen, PA-C

1716 Williams Hwy., Grants Pass, OR 97527 | Phone (541) 474-6053 | Fax (541) 474-4527



Health History *(continued)*

MEDICATIONS

Do you have any trouble taking any of your medications? ☐ Yes ☐ No

(If you need more room to list additional medications, please write them on a blank sheet of paper with the required information)

Medications <i>(please list all)</i>	Dose <i>(Mg., pill, etc.)</i> and Frequency <i>(once daily, twice, etc.)</i>

ALLERGIES

Allergies <i>(environmental, food, drug)</i>	Reaction <i>(symptoms)</i>

FAMILY HISTORY

Father (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Mother (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Brother/Sister (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Brother/Sister (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Children How Many: _____ Age: _____ Health: _____

PREVIOUS SURGERIES *(if additional surgeries attach an additional sheet of paper)*

Type	Year
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

Date of Last Colonoscopy: _____ Date of Last Bone Density: _____



Jon E. L. Ermshar, MD | Brett Rasmussen, PA-C

1716 Williams Hwy., Grants Pass, OR 97527 | Phone (541) 474-6053 | Fax (541) 474-4527



Health History *(continued)*

Women Only

First menstrual cycle (age) _____ Present form of birth control _____
Date of last menstrual cycle _____ # of pregnancies _____ Full-term _____ Live births _____
Date of last mammogram _____ Date of last pap smear _____

LIFESTYLE

Occupation: _____

Married Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partnership ☐ Widowed

Caffeine: How much caffeine do you consume per day? (e.g. coffee, tea, chocolate, soda) _____

Alcohol

How many drinking days do you have per week? _____ On average, how many drinks per drinking day? _____

Are you or others concerned about your drinking? ☐ Yes ☐ No

Tobacco and Vape Use

Do you currently use any forms of tobacco or do you vape? (please specify what type) _____

If yes, how frequently is your usage? _____ Are you interested in quitting? ☐ Yes ☐ No

Drug Use

Do you have a history of Drug use? ☐ Yes ☐ No (if yes, what substance) _____

Exercise/Activity

What Type of Exercise do you do (example: walking, swimming, running)? _____

How long? _____ How often? _____

Fall3

Have you fallen in the past year? ☐ Yes ☐ No

Do you have problems with walking or balance? ☐ Yes ☐ No

Safety

Are you in a relationship that makes you feel unsafe or have been hurt? ☐ Yes ☐ No

Do you regularly wear a seatbelt? ☐ Yes ☐ No

HIV Testing

Would you like HIV testing? ☐ Yes ☐ No (If yes, please tell the Medical Assistant). HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease or history of drug use, sex workers, sexual partners of HIV-infected persons, or persons at risk.

Hepatitis C Testing

Have you ever been tested for Hepatitis C? ☐ Yes ☐ No

The United States Preventative taskforce recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years at least once in a lifetime.



Jon E. L. Ermshar, MD | Brett Rasmussen, PA-C

1716 Williams Hwy., Grants Pass, OR 97527 | Phone (541) 474-6053 | Fax (541) 474-4527