EOU Student Health Center

1 University Blvd, La Grande, OR 97850

Patient Name: _____ Date: _____

SURGICAL HISTORY

Indicate any major surgeries and dates of surgery (if you choose OTHER please describe):

_____ No Surgery

Eyes	**( ) Cataract _____ ( ) Lasik Surgery _____ ( ) Tear Duct _____ ( ) Other _____**
Ears	**( ) Tubes _____ ( ) Eardrum _____ ( ) Mastoid _____ ( ) Other _____**
Nose	**( ) Septoplasty _____ ( ) Rhinoplasty _____ ( ) Sinus Surgery _____ ( ) Other _____**
Throat	**( ) Adenoidectomy _____ ( ) Tonsillectomy _____ ( ) Other _____**
Neck	**( ) Thyroidectomy _____ ( ) Other _____**
Heart	**( ) Angioplasty _____ ( ) Bypass _____ ( ) Valve _____ ( ) Stent _____ ( ) Other _____**
Digestive	**( ) Appendectomy _____ ( ) Gallbladder _____ ( ) Hiatal Hernia _____ ( ) Other _____**
Female Health	**( ) Uterine _____ ( ) Ovary _____ ( ) Cervix _____ ( ) Other _____**
Male Health	**( ) Testicle _____ ( ) Prostate _____ ( ) Other _____**
Musculoskeletal	**( ) Joint _____ ( ) Fracture _____ ( ) Ligament _____ ( ) Tendon _____ ( ) Other_____**
Other	**( ) Head Injury _____ ( ) Motor Vehicle Accident _____ ( ) Any other major surgery _____**

Please List any Hospital Admissions other than above: _____ No Hospitalization _____

_____

_____

Reason for hospitalization: _____

_____

SOCIAL HISTORY

(Please be honest when circling the best answer, this can affect treatment choices, medication selections and dosing. Answers are confidential except as limited by law)

Do you drink alcohol? YES / NO / QUIT If so, how often and how much? Beer / Liquor / Wine / Other _____
Do you exercise on a regular basis? YES / NO If so, how often? 1-3 times a week / 4 times a week or more (please circle one)
Health Status: Are in POOR HEALTH / FAIR HEALTH / GOOD HEALTH / EXCELLENT HEALTH (please circle one)
Are your hobbies INDOOR or OUTDOOR? (please circle one)
Is your occupation INDOOR or OUTDOOR? (please circle one)
Do you use recreational drugs? YES / NO / QUIT If so, what type(S), how often and how much? _____
Do you use Sunscreen? ALWAYS / MOST OF THE TIME / NEVER / OCCASSIONALLY / DAILY (please circle one)
Do you use tobacco? YES / NO / QUIT If so, how often and how much? _____
Cigarette / Cigar / Pipe / Chew / Second Hand Smoke
When did you start? Age _____ or Year _____ When did you stop? Age _____ or Year _____
Do you tan routinely? YES / NO If so, do you use a tanning bed
Females Only – Are you nursing? YES / NO Are you pregnant or trying to get pregnant? YES / NO

FAMILY HISTORY

Please circle yes if any IMMEDIATE family members (even if deceased) have or had any of the following:

_____ No Family History Problems Known					Explain
_____ Adverse reaction to anesthesia	Mother	Father	Brother	Sister	_____
_____ Arthritis	Mother	Father	Brother	Sister	_____
_____ Cancer	Mother	Father	Brother	Sister	_____
_____ Excessive Bleeding	Mother	Father	Brother	Sister	_____
_____ Heart Problems	Mother	Father	Brother	Sister	_____
_____ Bleeding or Clotting Problems	Mother	Father	Brother	Sister	_____
_____ Melanoma	Mother	Father	Brother	Sister	_____
_____ Tuberculosis	Mother	Father	Brother	Sister	_____
_____ Substance Abuse	Mother	Father	Brother	Sister	_____
_____ Other	Mother	Father	Brother	Sister	_____