EOU Student Health Center

1 University Blvd, La Grande, OR 97850

PATIENT MEDICAL HISTORY

Patient Legal Name: _____ Date: _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Circle YES or NO)

CARDIOVASCULAR

High/Low Blood Pressure	Yes	No
Cardiac Disease	Yes	No
Heart Valve Conditions/Replacement	Yes	No
Murmur	Yes	No
Pacemaker	Yes	No
Varicose Veins	Yes	No

DERMATOLOGIC

Acne	Yes	No
Eczema	Yes	No
Excessive Scarring	Yes	No
Hair Loss	Yes	No
Hives	Yes	No
Itching	Yes	No
Nail Problems	Yes	No
Psoriasis	Yes	No
Reaction to Jewelry	Yes	No
Skin Cancer	Yes	No
Recurrent or Chronic Skin Infections	Yes	No
Sun Sensitivity	Yes	No

ENDOCRINE

Diabetes	Yes	No
Thyroid Disorder	Yes	No

GASTROINTESTINAL

Difficulty Swallowing	Yes	No
Liver Conditions	Yes	No
GERD / Ulcer	Yes	No

GU/RENAL

Dialysis	Yes	No
Kidney Disease	Yes	No

FEMALE REPRODUCTIVE

Excessive Bleeding	Yes	No
Irregular Menstrual Cycles	Yes	No
Miscarriages	Yes	No
Pregnancy	Yes	No
Breast Cancer / Breast Lumps	Yes	No

MALE REPRODUCTIVE

Testicular Cancer / Testicular Lumps	Yes	No
Difficulty Obtaining / Sustaining Erections	Yes	No

HEENT

Glaucoma	Yes	No
Sinus Conditions	Yes	No
Tubes in Ears	Yes	No
Frequent or Chronic Ear/Nose/Throat Infections	Yes	No

HEMATOLOGIC

Anemia	Yes	No
Bone Marrow Cancer	Yes	No
Bruise or Bleed Easily	Yes	No
Leukemia or Lymphoma	Yes	No
Low Platelets	Yes	No
Low White Blood Cells	Yes	No
Blood Clots	Yes	No

IMMUNOLOGIC

Cold Sores	Yes	No
Hepatitis B or C	Yes	No
Herpes	Yes	No
HIV/AIDS	Yes	No
Tuberculosis	Yes	No
Warts	Yes	No

IMPLANTS AND METALS

Breast Implants	Yes	No
Prostheses	Yes	No
Screws/Plates	Yes	No

MUSCULOSKELETAL

Arthritis Conditions	Yes	No
Gout	Yes	No
Joint Pain	Yes	No
Lupus	Yes	No
Muscle Pain/Weakness	Yes	No
Traumatic Injury	Yes	No

NEUROLOGIC

Fainting	Yes	No
Headaches	Yes	No
Seizure Disorders	Yes	No
Stroke	Yes	No

PSYCHIATRIC

Anxiety Disorder	Yes	No
Chemical Dependency	Yes	No
Depression	Yes	No
Eating Disorders	Yes	No
Phobia	Yes	No

RESPIRATORY

Abnormal Chest X-ray	Yes	No
Asthma	Yes	No
Bronchitis / Pneumonia	Yes	No
Lung Cancer	Yes	No
Shortness of Breath	Yes	No

OTHER: _____

Please explain any 'Yes' answers here: _____

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