



1914 Willamette Falls Drive, Suite 210
 West Linn, OR 97068
 503-655-9727

PATIENT HEALTH ASSESSMENT

NAME: _____ DOB: _____
 Reason for Visit _____

Ht. ____ft ____in	Wt. _____lb	EKG if over 50 Y(date_____) N	Circle if you use: Caffeine Alcohol- ____/wk Cigarettes/Tobacco- ____/day Recreational drugs____	Female: Pregnant Y N
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List all **SURGERIES / MEDICAL CONDITIONS** with date of occurrence including snoring/sleep apnea.(use the back if needed)

List all **ALLERGIES**: to include medication, food, or seasonal allergies

List all **MEDICATIONS** or drugs you are now taking or have taken in the last month (including birth control pills, herbal supplements, vitamins, over-the-counter medications).

Family Medial History:

Do you have:

Y N Y N

Latex sensitivity			Diabetes: Type I	Type II		
Shortness of breath			Glaucoma			
Sleep Apnea- CPAP machine			Thyroid problems			
Heart palpitations			Bruising/bleeding			
Heart problems			Nausea from medications			
Stroke			Motion sickness			
High blood pressure			Seizures			
Fever blisters			Hiatal hernia/gastric reflux			
Asthma Wheezing Inhaler			Hepatitis: A B C			

Emergency Contact Name: _____ Phone: _____

CONSENT FOR TRANSFER

In the event of an emergency or the necessity to be transported to a hospital facility, permission is given to Dr. Gregory L. Combs to arrange transfer by ambulance.

Patient Signature _____ Date _____