GREGORY L COMBS MD., PC.
1914 Willamette Falls Dr., Suite 210
West Linn, OR. 97068

PATIENT HEALTH ASSESSMENT

NAME: _____

Reason for Visit_____

Height_____ Weight_____ Female: pregnant - Yes No

MEDICAL CONDITIONS: (Check ALL that apply)

- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ DIABETES I/II
- ☐ LUNG DISEASE (COPD, Asthma, Emphysema)
- ☐ GASTRO INTESTINAL DISEASE
- ☐ CANCER (type) _____
- ☐ HEPATITIS A/B/C
- ☐ THYROID DISEASE
- ☐ ARTHRITIS
- ☐ KIDNEY DISEASE
- ☐ NEUROLOGIC DISEASE_____
- ☐ PSYCHIATRIC DISEASE_____
- ☐ OTHER_____
  _____

SURGERIES:

_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES:

_____
_____
_____

List all **MEDICATIONS** you currently take, including over-the-counter, herbal supplements and prescriptions.

Medication:	**Purpose:**	**Dose (mg):**	**Frequency:**

(use back if needed)

FAMILY HISTORY: (Check ALL that apply)

- ☐ CANCER
- ☐ HEART DISEASE
- ☐ MALIGNANT HYPERTHERMIA
- ☐ HYPERTENSION
- ☐ DIABETES
- ☐ ARTHRITIS

Patient Signature_____Date _____

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REVIEW OF SYSTEMS

Please circle Yes or No for each area for any problems you have had **recently**. If "Y", provide information

GENERAL SYMPTOMS Fever, Chills, Unexplained Weight Loss, Weight Gain, Trouble Sleeping, Poor Appetite, or Fatigue.	Y / N	_____
SKIN Acne, Warts, Skin Cancer, Rash, Hives, Change in Moles.	Y / N	_____
VISION Double Vision, Vision Loss, Visual Obstruction, Dry Eyes, Cataracts, Glaucoma.	Y / N	_____
EAR, NOSE, THROAT Sinus, Cough, Trouble Swallowing, Ear Pain, Ringing in Ears, Loss of Hearing.	Y / N	_____
CARDIOVASCULAR Chest Pain, Irregular Heart Beat, High Blood Pressure.	Y / N	_____
RESPIRATORY Shortness of Breath, Cough, Wheezing, Oxygen Requirement.	Y / N	_____
GASTROINTESTINAL Nausea, Vomiting, Constipation, Diarrhea, Blood in Stools, Abdominal Pain, Change In Bowel Habits.	Y / N	_____
GENITAL, KIDNEY, BLADDER Blood in Urine, Painful Urination, Frequent Urination, Lack of Bladder Control.	Y / N	_____
MUSCLE, BONES, JOINTS Joint Pain, Numbness, Weakness.	Y / N	_____
NEUROLOGICAL Headache, Memory Problems, Speech Difficulty, Seizures, Dizziness, Weakness, Numbness, Walking Difficulty.	Y / N	_____
PSYCHIATRIC Anxiety, Depression, Hallucinations.	Y / N	_____
ENDOCRINE Feel Hot or Cold, Hair Loss, Fatigue.	Y / N	_____
HEMATOLOGIC History of Anemia, Bruising, Excessive Bleeding.	Y / N	_____
ALLERGIC/IMMUNOLOGIC Hay Fever, Asthma, Hives, Dry Allergy.	Y / N	_____

Patient Signature_____Date _____

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SOCIAL HISTORY:

Occupation: _____

Education: • High School • College • Graduate School • Technical School • Professional School

Do you drive? _____

Living arrangements: (alone, assisted living, with family_____

Dietary Restrictions: _____

Hobbies/Activities: _____

Exercise: Y / N Type _____ Frequency _____

Alcohol Use: Y / N _____/day Tobacco Use: Y / N _____/day Marijuana Use: Y / N _____/day

Other: _____

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 _____