Mid-Columbia Center for Living **Name:** #
Confidential Medical Questionnaire **Date:**

List any medical or emotional conditions for which you are **NOW** being treated:

Have you ever had an allergic reaction to any medication? _____Yes _____No
If yes, what medicine and what reaction?

Do you have any seasonal or environmental allergies: _____Yes _____ No
If yes, to what are you allergic and what are the symptoms?

Please check any medical problem you have had in the past:

√	Year Diagnosed		√	Year Diagnosed	
		Anxiety / Panic Attack(s)			High Blood Pressure
		Arthritis			Injuries / Accidents
		Asthma			Kidney Infection/Stones
		Autoimmune Disease			Liver Disease / Hepatitis
		Bipolar Disorder			Loss of Consciousness
		Blood Disorders			Low Back Pain
		Bowel Disease			Pulmonary / Lung Disease
		Cancer: Type _____			Sexually Transmitted Disease
		Chronic Fatigue Syndrome			Shakes or Tremors
		Dental Problems			Sleep Disorders
		Depression			Stroke
		Diabetes: Type 1 ___ Type 2 ___			Thyroid Disorder
		Eating Disorder			Traumatic Brain Injury
		Eye Disease / Vision Problems			Tuberculosis - Tested Positive
		Fibromyalgia / Lupus			Ulcers
		Gallbladder Disease / Stones			Urinary Incontinence or Bedwetting
		Headaches / Migraine			Weight Gain/Loss - Unintentional
		Hearing Problems / Hard of Hearing			Other:
		Heartburn / Hiatal Hernia			
		Heart Disease			

List **ALL** of the ***Prescribed, Over-the-Counter*** and ***Herbal*** medicines you are taking. Be sure to include medications for colds/allergies, heart trouble, high blood pressure, thyroid, "water", birth control, and sleeping aids, etc.

Name of medication	Dose	How often taken	For what reason	Side effects or problems

Which Pharmacy Do You Use?

Pharmacy Name: _____

☐ The Dalles ☐ Hood River ☐ Other _____