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Adult Health History

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all five pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

_____

PATIENT NAME TODAY'S DATE DATE OF BIRTH

Main reason for today's visit: _____

Other concerns: _____

What are your health goals for the next year? _____

Where were you getting your healthcare before? _____

In the past two weeks, have you been bothered by:

Little interest or pleasure in doing things? ☐ Yes ☐ No

Feeling down, depressed, or hopeless? ☐ Yes ☐ No

REVIEW OF SYMPTOMS

Please check and circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

GENERAL
- ☐ Unexplained weight loss / gain
- ☐ Unexplained fatigue / weakness
- ☐ Fall asleep when sitting, day
- ☐ Fever or chills
- ☐ NO problems

SKIN
- ☐ New or change in mole
- ☐ Rash / itching
- ☐ NO problems

BREAST
- ☐ Breast lump, pain, nipple discharge
- ☐ NO problems

EARS/NOSE/THROAT
- ☐ Nosebleeds, trouble swallowing
- ☐ Frequent sore throats, hoarsness
- ☐ Hearing loss / ringing in ears
- ☐ NO problems

EYES
- ☐ Change in vision / eye pain / redness
- ☐ NO problems

CARDIOVASCULAR
- ☐ Chest pain / discomfort
- ☐ Palpitations (fast or irregular heartbeat)
- ☐ NO problems

RESPIRATORY
- ☐ Cough / wheeze
- ☐ Loud snoring / altered breath
- ☐ Shortness of breath w/ exertion
- ☐ NO problems

GASTROINTESTINAL
- ☐ Heartburn / reflux / indigestion
- ☐ Blood or change in bowel movement
- ☐ Constipation
- ☐ NO problems

GENITOURINARY
- ☐ Leaking urine
- ☐ Blood in urine

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☐ Nighttime urination or increased frequency
☐ Discharge: penis or vagina
☐ Concern w/ sexual function
☐ **NO problems**

MUSCULOSKELETAL
☐ Neck pain
☐ Back pain
☐ Muscle / join pain
☐ NO problems

ENDOCRINE
☐ Heat or cold sensitivy
☐ NO problems

HEMATOLOGIC/LYMPHATIC
☐ Swollen glands
☐ Easy bruising
☐ NO problems

NEUROLOGICAL
☐ Headache
☐ Memory loss
☐ Fainting
☐ Dizziness
☐ Numbing / tingling
☐ Unsteady gait
☐ Frequent falls
☐ NO problems

ALLERGIC / IMMUNE
☐ Hay fever / allergies
☐ Frequent infections
☐ NO problems

PSYCHIATRIC
☐ Anxiety / stress / irritability
☐ Sleep problems
☐ Lack of concentration
☐ NO problems

WOMEN ONLY
☐ Premenstrual symptoms (bloating, cramps, irritability)
☐ Problem with menstrual periods
☐ Hot flashes / night sweats
☐ NO problems

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known.
Check this box if you don't know the information: ☐

☐ Tetanus (Td) _____
☐ Varicella (Chicken Pox) shot or illness_____
☐ Influenza (flu shot) _____
☐ Hepatitis B _____
☐ Zostavax (shingles) _____
☐ Tetanus w/ Pertussis (Tdap) _____
☐ Pneumovax_____
☐ Hepatitis A _____
☐ MMR _____
☐ HPV _____

WOMEN'S HEALTH HISTORY
Total number of pregnancies _____
Age at beginning of periods _____
Date of last menstrual period (if still menstruating) _____
Age at end of periods (menopause) _____

MEDICATIONS
Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. ☐ I take no medications

MEDICATION	DOSE (e.g. mg/pill)	HOW MANY TIMES PER DAY?

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Any allergies or intolerance to medications (include type of reaction)?:

☐ I have no allergies

PERSONAL MEDICAL HISTORY: Do you have (now) or have you had (past) any of the following conditions?

☐ NONE

Condition	Now	Past	Comments
Alcohol / Drug use			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema			
Fractures (broken bones)			WHERE?:
Gallbladder Disease			
Gastroesophageal Reflux			
Glaucoma			

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Condition	Now	Past	Comments
Gout			
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (Eczema)			
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) /			
Thyroid Low (Underactive) /			
Other (list)			
Other (list)			

SURGICAL HISTORY: Please check off any procedure or surgeries. List any abnormal findings or complications.

Surgical Procedure	No	Yes	Year	Comments
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy				Circle: Right Left Both
Breast Surgery				Circle: Right Left Both
Colonoscopy				

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Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				Circle: Laparoscopic
Heart Surgery (other than coronary bypass)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal

Knee Surgery				Circle: Right Left Both
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation ("Tubal")				
Ovary Removal				Circle: Right Left Both
Vasectomy				
Sigmoidscopy				
Sinus Surgery				
Other (list)				

Are you adopted? ☐ Yes* ☐ No

*If yes, and you do NOT know your family history, please skip to section "Other Health Issues".

DISEASE	MOTHER	FATHER	SISTER(S)	BROTHER(S)	MOM'S MOM	MOM'S DAD	DAD'S MOM	DAD'S DAD	OTHER RELATIVES	COMMENTS
No significant history known										
Alcohol / Drug abuse										
Allergic Disorder										
Cancer										
Diabetes										
Gastrointestinal Disorder										
Heart Disease										
Hypertension										
Kidney Disease										
Mental Illness										
Migraine Headache										
Myocardial Disorder										
Respiratory Disorder										
Seizure Disorder										
Stroke Syndrome										
Tuberculosis										

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OTHER HEALTH ISSUES

Tobacco Use
Smoke cigarettes: ☐ Yes ☐ No
☐ Never (If you never smoked, please skip to alcohol section)

Quit Date:
How many years did you smoke? _____
How many packs a day did you smoke? _____

Current smoker:
Packs per day: _____
Number of years: _____

Oher tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alochol Use
Do you drink alcohol?
☐ Yes ☐ No
Number of drinks per week: _____
☐ Beer ☐ Wine ☐ Liquor

Drug Use
Have you used marijuana or recreational drugs?
☐ Yes ☐ No

Have you ever used needles to inject drugs?
☐ Yes ☐ No

Sexual Activity
Sexually involved currently?
☐ Yes ☐ No

Sexual partners have been:
☐ Male ☐ Female

Birth control method (circle all that apply):

Condom, pill, diaphragm, vasectomy, other
_____

Exercise
Do you exercise regularly?
☐ Yes ☐ No

What kind of exercise?
_____
_____
_____

How long (minutes): _____
How often: _____

Diet
How would you rate your diet?
☐ Good ☐ Fair ☐ Poor
Would you like advice on your diet?
☐ Yes ☐ No

Safety
Do you use a bike helmet?
☐ Yes ☐ No ☐ No bike

Do you use seatbelts consistently?
☐ Yes ☐ No

Does your home have a working smoke detector?
☐ Yes ☐ No

If you have guns in your home, are they locked up?
☐ Yes ☐ No ☐ Not applicable
Is violence in your home a concern for you?
☐ Yes ☐ No

Have you completed any of the following: (please check all that apply)
☐ Advance Directive for Helathcare (ADHC) ☐ Living Will
☐ POLST (Physician Orders for Life Sustaining Therapy)

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SOCIAL HISTORY

Occupation (or prior occupation): _____

If not currently employed, please circle one:
☐ Retired ☐ Unemployed ☐ Leave of absence ☐ Disabled

Employer: _____

Years of education or highest degree: _____

Marital status (please check one):
☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Spouse/partner name: _____

Number of children: _____

Age(s) if under 18 years: _____

Number of grand children: _____

Number of great grandchildren: _____

Who lives at home with you?

_____

_____

_____

Leisure activities, group involvement, religion, volunteer work, recent travel:

_____

_____

For Internal Use Only: MRN_____

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME_____
Last *First* *Middle*

PREVIOUS NAME(S)_____ **GENDER:** M____ F____

STREET ADDRESS / P.O. BOX_____

CITY_____ **STATE**_____ **ZIP CODE**_____

PHONE NUMBER _____ **EMAIL**_____

DATE OF BIRTH _____(MM)_____(DD)_____(YYYY)

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

_____ _____
Signature of patient or authorized representative Date Time

If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

_____ _____ _____
Name of Authorized Representative (Printed) Relationship Date Time

_____
Address of authorized representative signing this form (please print):

_____
Phone number of authorized representative

FOR INTERNAL USE ONLY
Name of Organization:_____ Name of Witness:_____
As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in health care.

Patient Consent Form for Electronic Exchange of Individual Health Information

HealtHIE Nevada is a non-profit organization dedicated to connecting the healthcare community to share information electronically and securely to improve the quality of healthcare services. To learn more about the Health Information Exchange (HIE), read the Patient Information brochure. You can ask the doctor that gave you this form for it, or go to the website www.healtHIEnevada.org.

Details about patient information in HealtHIE Nevada and the consent process:

1. **How your information will be used and who can access it:** When you provide consent, only HealtHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers, and pharmacies), will have access to your health information. It can only be used to:
   - Provide you with medical treatment and related services.
   - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information.
2. **Types of information included and where it comes from:** The information about you comes from organizations that have provided you with medical care, and are HealtHIE Nevada participants. These may include hospitals, physicians, pharmacies, clinical laboratories, and other healthcare organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this Consent Form. This information may relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental health conditions
   - Sexually transmitted diseases
3. **Improper Access or Disclosure of your Information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada State Law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.
4. **Effective Period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealtHIE Nevada ceases to conduct business.
5. **Revoking your consent:** At any time, you may revoke your consent by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

Note: Organizations that access your health information through HealtHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. **How your information is protected:** Federal and State laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada State law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

Copy of Form: You are entitled to receive a copy of this Consent Form after you sign it.