NORTHERN NEVADA HOPES *your partner in health.*

Adult Health History | New Patient

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are uncomfortable with any question, please do not answer it. Thank you!

____

PATIENT NAME TODAY'S DATE DATE OF BIRTH

Reason for visit: ____

____

What are your health goals? ____

Previous healthcare provider? ____

Specialists (Past or Present)____

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 don't check any boxes if none of the symptoms apply to you.

☐ No Problems With My Health

GENERAL

☐ Unexplained weight loss / gain
☐ Unexplained fatigue / weakness
☐ Fall asleep when sitting, day
☐ Fever or chills

SKIN

☐ New or change in mole
☐ Rash / itching

BREAST

☐ NO problems
☐ Breast lump, pain, nipple discharge

EARS/NOSE/THROAT

☐ NO problems
☐ Nosebleeds
☐ Trouble swallowing
☐ Frequent sore throats, hoarseness
☐ Hearing loss / ringing in ears

EYES

☐ Change in vision / eye pain / redness

CARDIOVASCULAR

☐ Chest pain / discomfort
☐ Palpitations (fast or irregular heartbeat)

RESPIRATORY

☐ Cough / wheeze
☐ Loud snoring / altered breath
☐ Shortness of breath w/ exertion

GASTROINTESTINAL

☐ Heartburn / reflux / indigestion
☐ Blood or change in bowel movement
☐ Constipation

GENITOURINARY

☐ Leaking urine
☐ Blood in urine
☐ Nighttime urination or increased frequency

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☐ Discharge: penis or vagina
☐ Concern w/ sexual function

MUSCULOSKELETAL
☐ Neck pain
☐ Back pain
☐ Muscle / join pain

ENDOCRINE
☐ Heat or cold sensitive

HEMATOLOGIC/LYMPHATIC
☐ Swollen glands

☐ Easy bruising

NEUROLOGICAL
☐ Headache
☐ Memory loss
☐ Fainting
☐ Dizziness
☐ Numbing / tingling
☐ Unsteady gait
☐ Frequent falls

ALLERGIC / IMMUNE
☐ Hay fever / allergies

☐ Frequent infections

PSYCHIATRIC
☐ Anxiety / stress / irritability
☐ Sleep problems
☐ Lack of concentration

WOMEN ONLY
☐ Premenstrual symptoms (bloating, cramps, irritability)
☐ Problem with menstrual periods
☐ Hot flashes / night sweats

WOMEN'S HEALTH HISTORY

Total number of pregnancies ___________
Date of last menstrual period (if still menstruating) _________
Age at beginning of periods ___________
Age at end of periods (menopause) ______________________
Date of last mammogram_________________
Date of last PAP Smear__________________________________
Contraception Method:______________________________
History of abnormal PAP results? ☐Yes ☐No

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?

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

____
____
____
____

☐ I have no allergies

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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)			

PROCEDURES/SURGICAL HISTORY: List all procedures and surgeries with date.

Date of last colonoscopy________________

DATE:

DATE:

DATE:

DATE:

DATE:

DATE:

DATE:

DATE:

DATE:

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FAMILY HISTORY:

Do you know your family health history? ☐Unknown

If you don't know your family history, please check the above box and skip to the "Other Health Questions" sections.

DISEASE	MOTHER	FATHER	SISTER(S)	BROTHER(S)	MOM'S MOM	MOM'S DAD	DAD'S MOM	DAD'S DAD	OTHER RELATIVES	COMMENTS
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										

OTHER HEALTH QUESTIONS

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: ______________

Other tobacco:

☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol 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 Healthcare (ADHC) ☐ Living Will

☐ POLST (Physician Orders for Life Sustaining Therapy)

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: ____

Who lives at home with you?

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.