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!

<table>
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<tr>
<th>PATIENT NAME</th>
<th>TODAY'S DATE</th>
<th>DATE OF BIRTH</th>
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</thead>
</table>

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
☐ Discharge: penis or vagina
☐ Concern w/ sexual function
☐ Easy bruising
☐ Frequent infections
☐ Neck pain
☐ Back pain
☐ Muscle / joint pain
☐ Headache
☐ Memory loss
☐ Fainting
☐ Dizziness
☐ Numbness / tingling
☐ Unsteady gait
☐ Frequent falls
☐ Heat or cold sensitive
☐ Swollen glands
☐ Hay fever / allergies
☐ Anxinity / stress / irritability
☐ Sleep problems
☐ Lack of concentration
☐ 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

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE (e.g. mg/pill)</th>
<th>HOW MANY TIMES PER DAY?</th>
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</table>

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**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Now</th>
<th>Past</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Alcohol / Drug use</td>
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<td>Allergy (Hay Fever)</td>
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<td>Anemia</td>
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<td>Anxiety</td>
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<td>Arthritis (Rheumatoid)</td>
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<td>Arthritis (Osteoarthritis)</td>
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<td>Asthma</td>
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<td>Bladder / Kidney Problems</td>
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<td>Blood Clot (leg)</td>
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<td>Blood Clot (lung)</td>
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<td>Blood Transfusion</td>
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<td>Breast Lump (benign)</td>
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<td>Cancer Breast</td>
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<td>Cancer Colon</td>
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<td>Cancer Other Type</td>
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<td>Cancer Ovarian</td>
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<td>Cancer Prostate</td>
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<td>Cataracts</td>
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<td>Chicken Pox</td>
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<td>Colon Polyp</td>
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<td>Coronary Artery Disease</td>
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<td>Depression</td>
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<td>Diabetes (adult onset)</td>
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<td>Diabetes (childhood onset)</td>
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<td>Diverticulosis</td>
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<td>Emphysema</td>
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<td>Fractures (broken bones)</td>
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<td>Gallbladder Disease</td>
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<td>Gastroesophageal Reflux</td>
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<td>Glaucoma</td>
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<td>Condition</td>
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<td>Gout</td>
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<td>Gynecological Conditions (Endometriosis)</td>
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<td>Gynecological Conditions (Other)</td>
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<td>Heart Attack</td>
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<td>Hepatitis – Type A</td>
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<td>Hepatitis – Type B</td>
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<td>Hepatitis – Type C</td>
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<td>Hepatitis – Other</td>
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<td>High Blood Pressure</td>
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<td>High Cholesterol</td>
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<td>Hip Fracture</td>
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<td>Irritable Bowel Syndrome</td>
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<td>Kidney Disease / Failure</td>
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<td>Pneumonia</td>
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<td>Prostate (enlargement)</td>
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<td>Prostate (nodules)</td>
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<td>Skin Condition (Abnormal Moles)</td>
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<td>Thyroid (Nodule)</td>
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<td>Other (list)</td>
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<td>Other (list)</td>
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**PROCEDURES/SURGICAL HISTORY:** List all procedures and surgeries with date.

Date of last colonoscopy__________________________  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.

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>MOTHER</th>
<th>FATHER</th>
<th>SISTER(S)</th>
<th>BROTHER(S)</th>
<th>MOM’S MOM</th>
<th>MOM’S DAD</th>
<th>DAD’S MOM</th>
<th>DAD’S DAD</th>
<th>OTHER RELATIVES</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Alcohol / Drug abuse</td>
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<td>Allergic Disorder</td>
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<td>Respiratory Disorder</td>
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<td>Stroke Syndrome</td>
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<td>Tuberculosis</td>
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**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?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
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 signers 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.
HealthHIE 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.healthHIEnevada.org.

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

1. **How your information will be used and who can access it:** When you provide consent, only HealthHIE 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 HealthHIE 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 HealthHIE 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 HealthHIE 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.