NORTHERN NEVADA HOPES *your partner in health.*

Adult Health History | New Patient

Today's Date_____

_____

PREFERRED NAME DATE OF BIRTH

Reason for visit: _____

What are your health goals for the next year? _____

Previous Primary care Provider? _____ Last visit? _____

Specialists (Past or Present)_____

_____

MEDICATIONS

Please list all prescriptions *and* non-prescription medications; vitamins, home remedies, supplements, herbs, etc.

☐ I take no medications

MEDICATION	DOSE	TIMES PER DAY	REASON FOR TAKING MED

Please list dates and location of most recent Preventative Care Screenings:

Mammogram_____ Colonoscopy_____

Pap smear_____ Tetanus shot_____

Cholesterol check_____ Flu shot_____

Stool check for blood_____ Pneumonia shot_____

Prostate test_____ Shingles shot_____

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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 abuse			
Allergies (Hay Fever)			
Anemia			
Arthritis (osteo or rheumatoid)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg or lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult or childhood)			
Diverticulosis			
Drug abuse			
Emphysema			
Fractures (broken bones)			WHERE?:
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD/ulcer)			
Glaucoma			
Gout			
Gynecologic disorders			
Heart Attack			
Hepatitis A, B, or C			
High Blood Pressure			
High Cholesterol			
Immune disorder (HIV/AIDS)			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Kidney Stones			
Liver Disease			
Mental illness (depression,			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate disorders			
Seizure/Epilepsy			
Sexually transmitted infections			
Skin Condition (Eczema, psoriasis)			

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

CONDITION	NOW	PAST	COMMENTS
Sleep Apnea			
Stroke			
Thyroid disorders			
Other (list)			

Any allergies or intolerance to medications (include type of reaction)?: ☐ I have no allergies

_____

_____

_____

Are you allergic to any specific foods (include type of reaction)?

_____

_____

Are you allergic to latex?

Yes_____ No_____

GYNECOLOGIC HISTORY	OBSTETRIC HISTORY
Are you having a period every month?	How many times have you been pregnant?
Heavy, light, or normal flow?	How many live births?
When was your last pap?	Abortions?
History of abnormal pap?	Miscarriages?
Date of last period?	C-section?
Have you had a sexually transmitted infection? (gonorrhea, chlamydia, syphilis, trich)	Pregnancy or delivery complications?
What are you using for birth control?	Vaginal deliveries?
Age at beginning periods?	
Age at ending periods?	

PROCEDURES/SURGICAL HISTORY: List all procedures and surgeries with approximate dates. For example: appendix removal, gallbladder removal, hysterectomy, orthopedic surgeries, tonsils removed, biopsies, etc.

DATE	PROCEDURE/SURGERY

HOSPITALIZATIONS: Have you ever been hospitalized overnight? Yes___ No___
If yes, please list reasons and approximate dates:

DATE	REASON FOR HOSPITALIZATION

FAMILY HISTORY:
If you don't know your family history, please skip to the "Habits" Section Adopted? Yes___ No___

Please list any known medical conditions for the relatives listed below. For example: diabetes, cancer, heart attack, stroke, high blood pressure, high cholesterol, alcohol abuse, drug abuse, depression.

RELATIVE	AGE	MEDICAL CONDITION	CAUSE OF DEATH (IF APPLICABLE)
Mom			
Dad			
Mom's Dad			
Mom's Mom			
Dad's Dad			
Dad's Mom			
Siblings			
Other Relatives			

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HABITS:

Tobacco Use

Smoke cigarettes: ☐ Yes ☐ No ☐ Never

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

Current smokers:
Packs per day: _____
Number of years: _____
Other tobacco:
☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Sexual History

Sexually involved currently? ☐ Yes ☐ No
Sexual partners have been: ☐ Male ☐ Female

Do you think of yourself as (circle all that apply):
Straight/heterosexual
Lesbian, gay or homosexual
Bisexual
Don't know

Gender History

What is your current gender identity?
☐ Male
☐ Female
☐ Transgender Male (female to male)
☐ Transgender Female (male to female)
☐ Other _____

What sex were you assigned at birth?
☐ Male ☐ Female

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

If YES: ☐ Beer ☐ Wine ☐ Liquor
Number of drinks per week _____

Drug Use

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

Have you ever used needles to inject drugs?
☐ Yes ☐ N

Exercise
Do you exercise regularly? ☐ Yes ☐ No
If YES: What kind of exercise?
_____
_____
How long (minutes): _____
How often: _____

Diet
Please describe your eating habits
(poor, well balanced, vegetarian, gluten-free etc)
_____
_____

Safety
Do you feel safe in your home? ☐ Yes ☐ No
Have you ever been physically, emotionally, or verbally abused by your partner or anyone else?
☐ Yes ☐ No

Would you like to speak to a behavioral health provider today? ☐ Yes ☐ No

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SOCIAL HISTORY

Occupation (or prior occupation): _____

Employer: _____

Years of education or highest degree: _____

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

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

Spouse/partner name: _____ Number of children: _____

Age(s) of children if under 18 years: _____

Who lives at home with you? _____

_____

CASE MANAGEMENT

Do you have access to enough food? ☐ Yes ☐ No

Do you currently have housing? ☐ Yes ☐ No

Do you have transportation to your medical appointments? ☐ Yes ☐ No

Do you have current legal stressors? ☐ Yes ☐ No

Would you like to speak to a case manager today? ☐ Yes ☐ No

Are you interested in completing any of the following: (please check all that apply)

☐ Advance Directive for Healthcare (ADHC)

☐ Living Will

☐ POLST (Physician Orders for Life Sustaining Therapy)

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REVIEW OF SYMPTOMS

Please ***circle*** any **persistent** symptoms you have had in the **past few months**.
Read through each section and mark any that apply to you in the **past few months.**

GENERAL
Unexplained weight loss, fatigue, weakness, fever, chills, night sweats

ALLERGIC / IMMUNE
Allergies, congestion, frequent infections, sneezing

EYES
Change in vision, eye pain, blurry vision, redness, eye discharge

EARS/NOSE/THROAT
Nosebleeds, trouble swallowing, frequent sore throats, hoarseness, hearing loss, ringing in ears, snoring

ENDOCRINE
Heat or cold sensitive, thyroid problems, frequent urination, hair loss, diabetes

RESPIRATORY
Cough, wheezing, shortness of breath with exertion, sputum production

BREAST
Breast lump, pain, nipple discharge, rash on breast

CARDIOVASCULAR
Chest pain, discomfort, palpitations (fast or irregular heartbeat), difficulty laying flat, heart murmur, fluid accumulation in legs

GASTROINTESTINAL
Heartburn, reflux, indigestion, blood or change in bowel movement, constipation, abdominal pain, diarrhea, nausea, vomiting

HEMATOLOGIC
Swollen glands, easy bruising, prolonged bleeding

WOMEN ONLY
Premenstrual symptoms (bloating, cramps, irritability), heavy bleeding during periods, hot flashes, night sweats, pelvic pain, vaginal discharge, pain with intercourse, genital sores, concern with sexual function

MEN ONLY
Discharge from penis, burning with urination, genital sores, concern with sexual function, nighttime urination

GENITOURINARY ALL
Urinary incontinence, blood in urine, painful urination

MUSCULOSKELETAL
Neck pain, back pain, muscle pain, joint pain, knee pain, hip pain, shoulder pain, swollen joints

PSYCHIATRIC
Anxiety, stress, irritability, sleep problems, lack of concentration, suicidal thoughts, substance/drug abuse, hallucination

SKIN
New/change in mole or lesion, rash, itching, eczema, psoriasis

NEUROLOGIC
Headache, memory loss, fainting, dizziness, numbness/tingling, unsteady gait, frequent falls, seizures

☐ No Problems With My Health