NORTHERN NEVADA HOPES *your partner in health.*

Adult Health History | New Patient

Today's Date_____

_____

LEGAL NAME PREFERRED NAME FORMER NAME(S) Date of Birth

Previous Primary Care Provider? _____ Last visit? _____

MEDICATIONS:

☐ I take no medications

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

MEDICATION	STRENGTH (mg)	TIMES PER DAY	REASON FOR TAKING MED

Any allergies or intolerance to medications, foods or latex (include the type of reaction)?:

☐ I have no allergies

_____

_____

_____

Please list the dates and location(s) of your most recent Preventative Care Screenings:

Mammogram _____Colon cancer screening _____

HIV Test _____Pap smear _____

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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/SPECIALISTS SEEN
Autoimmune disorders (Rheumatoid arthritis, Lupus, etc.)			
Blood Clot (leg or lung)			
Cancer			
Coronary Artery Disease/Heart Attack			
Diabetes (adult or childhood)			
GI Issues (heartburn, colon polyps, diverticulosis, etc.)			
Hepatitis A, B, or C			
High Blood Pressure			
High Cholesterol			
HIV/AIDS			
Kidney Disease/Failure, Kidney Stones			
Mental illness (depression, anxiety, bipolar etc.)			
Osteoporosis			
Respiratory Conditions (Asthma, Sleep Apnea, COPD)			
Seizure/Epilepsy			
Sexually transmitted infections			
Skin Conditions (Eczema, psoriasis, etc.)			
Stroke			
Substance Use Disorder (opioids, meth, alcohol, etc.)			
Thyroid disorders			
Other (list)			

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?
Date of last period?	Abortions?
History of abnormal pap?	Miscarriages?
What are you using for birth control?	# of c-sections?
Age at beginning periods?	# of vaginal deliveries?
Age at ending periods?	Pregnancy or Delivery complications?

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HOSPITALIZATIONS: Please list overnight hospitalizations, date of hospitalization and which hospital:

_____

_____

_____

PROCEDURES/SURGICAL HISTORY: Please list type of surgery, date of surgery and which hospital:

_____

_____

_____

FAMILY HISTORY: Do you have a family history (parents, grandparents, siblings) of any of the following? If yes, please check box

☐ Diabetes
☐ High Blood Pressure
☐ Coronary Artery Disease/Heart Attack
☐ Mental Illness/Substance Abuse
☐ Cancer
☐ Stroke
☐ Other

Please explain any boxes you checked:

_____

_____

_____

Adopted? ☐ Yes ☐ No

SOCIAL HISTORY

Marital status (please check one):

☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Who lives at home with you? _____

Occupation and Employer?

_____

Highest Level of Education? _____

Are you currently housed? ☐ Yes ☐ No

BEHAVIORAL HEALTH

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

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

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Nicotine Use

☐ Current cigarette use: _____ packs per day Start date _____

☐ Past cigarette use: _____ packs per day Quit date _____ # of years smoked _____

☐ Other nicotine use: ☐ Pipe ☐ Cigar ☐ Vape ☐ Chew

☐ Never cigarette use

Alcohol Use

Do you drink alcohol? ☐ current ☐ past ☐ never Number of drinks per week _____

Drug Use

Marijuana: ☐ current ☐ past ☐ never Recreational drugs: ☐ current ☐ past ☐ never

IV drug use: ☐ current ☐ past ☐ never

Sexual Health

Have you had sex in the past 12 months? ☐ 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 or undefined Other

Gender Identity

What is your current gender identity?

☐ Male ☐ Female ☐ Transgender Male (female to male) ☐ Transgender Female (male to female)

☐ Gender Queer, neither exclusively male or female

☐ Other _____

What are your preferred pronouns? _____

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