Nehalem Bay Health Center – New Patient History Form

Today's Date: _____

Patient Name: _____ **DOB:** _____

New patient concern: _____

Other providers that you see: _____

Current medication(s), including vitamins, supplements/herbs (include dose and quantity) or bring in current medication bottles:

_____

_____

_____

_____

Pharmacy preference: _____

Allergies to medications: _____

Other allergy type(s): _____

Immunizations needed:

☐ None – patient up to date
☐ Flu
☐ Tetanus/Pertussis (whooping cough)
☐ Pneumonia
☐ Shingles
☐ Hep B
☐ Meningitis
☐ HPV
☐ Hep A
☐ Others: _____

Medical history: current and/or have a history of: Check all that apply

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis/Joint disorder
☐ Asthma
☐ Blood Transfusion
☐ Cancer (type)
_____
☐ Cataracts
☐ Clotting Disorder
☐ COPD
☐ Depression
☐ Diabetes Type: _____
Insulin? _____
Complications? _____
☐ Emphysema/COPD
☐ Glaucoma
☐ Heart Disease
Type: _____
☐ Heart Failure
☐ Heart Murmur
☐ HIV/AIDS
☐ Hyperlipidemia
☐ Hypertension
☐ Kidney Disease
Type: _____
☐ Liver Disease
☐ Meningitis
☐ Myocardial Infarction
☐ Nerve/Muscle Disease
Type: _____
☐ Osteoporosis
☐ Seizures
☐ Sickle Cell Anemia
☐ Stomach Ulcers
☐ Stroke
☐ STD
☐ Thyroid Disease
☐ Tuberculosis
☐ Other: _____

Name: _____ DOB: _____ Date: _____

Past Surgical History: Write in the date next to the surgery, if applicable

Surgery	Date	Surgery	Date	Surgery	Date
Appendectomy		C-Section		Small Intestine Surgery	
Brain Surgery		Eye Surgery		Spine Surgery	
Breast Surgery		Fracture Surgery		Tubal Ligation	
CABG		Hernia Repair		Valve Replacement	
Cholecystectomy		Hysterectomy		Vasectomy	
Colon Surgery		Joint Replacement		Cosmetic Surgery	
Prostate Surgery		Gender-Affirming			

Family History: please check all that applies for your family history. Please circle sex on the siblings.

	Mother - Age	Father - Age	Sibling 1 M/F	Sibling 2 M/F	Sibling 3 M/F
Alive					
Deceased					
Bleeding disorder					
Cancer (type)					
Depression					
Diabetes					
Heart Disease/heart attack					
High cholesterol					
Hypertension					
Kidney disease					
Mental Illness					
Stroke					
Substance abuse					
Thyroid disease					
Other					

Social History:

Smoking:

☐ Never Smoked ☐ Former Smoker (Start Date: _____ Quit Date: _____)

☐ Current Smoker Types: ☐ Cigarettes ☐ Cigars ☐ Pipe

Passive Smoke Exposure: ☐ Never ☐ Past ☐ Current

How many years have you smoked? _____

How often do you smoke? ☐ Every day ☐ Some days ☐ Other: _____

How many cigarettes do you smoke each day? _____ or How many packs per day? _____

Name: _____ DOB: _____ Date: _____

Smokeless Tobacco:
☐ Never Used ☐ Former User (Start Date: _____ Quit Date: _____)
Types: ☐ Chew ☐ Snuff

E-Cigarette/Vaping Use:
☐ Never Used ☐ Current Every Day User ☐ Current Some Day User
☐ Former User (Start Date: _____ Quit Date: _____)

Cartridges/Day _____

Ready to Quit? ☐ Yes ☐ No

Alcohol Use: ☐ Yes ☐ No ☐ Not Currently ☐ Never
☐ Former User (Start Date: _____ Quit Date: _____)

How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week
☐ Choose not to answer

How many drinks containing alcohol do you have on a typical day when you are drinking?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more ☐ Choose not to answer

How often do you have six or more drinks on one occasion?
☐ Never ☐ Monthly or less ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐ Choose not to answer

Drinks per week?
Glasses of wine/week: _____ Beers/week: _____ Shots of liquor/week: _____

Substance Use:
☐ None ☐ Yes ☐ Former User (Start Date: _____ Quit Date: _____)
If yes, which kind: ☐ Amphetamines ☐ Barbiturates ☐ Benzodiazepines ☐ Cocaine ☐ Crack ☐ Ecstasy
☐ Hashish ☐ Heroin ☐ IV ☐ Ketamine ☐ LSD ☐ Marijuana ☐ Methamphetamine ☐ Mescaline
☐ Nitrous Oxide ☐ Opioids ☐ PCP ☐ Prescription Stimulants ☐ Psilocybin ☐ Solvent Inhalants
☐ E-cigs ☐ Nicotine Vaping ☐ Other: _____

How many times per week? _____

Name: _____ DOB: _____ Date: _____

Sexual History:
Are you sexually active? ☐ Yes ☐ Never ☐ Not currently

Birth Control/Protection:
☐ Abstinence ☐ Cervical Cap ☐ Condom ☐ Diaphragm ☐ Hormonal patch ☐ Implant ☐ Injection
☐ Inserts ☐ IUD ☐ IUS ☐ Menopause ☐ Pill ☐Rhythm ☐ Spermicide
☐ Sponge ☐ Surgical ☐ Vaginal Ring ☐ Withdrawal ☐ Vasectomy ☐ None

Partners: ☐ Female ☐ Male

OB/Gyn Status:
# of pregnancies: ____ # of miscarriages: ____ # of abortions: ____ # of deliveries: ____
Currently pregnant: ☐ Yes ☐ No
Menstrual Status: ☐ Having periods ☐ Perimenopausal ☐ Postmenopausal ☐ Other_____
Last menstrual period (date): _____

Sexual Orientation and Gender Identity (SOGI)

Patient's Sexual Orientation:
☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Don't know
☐ Choose not to disclose ☐ Pansexual ☐ Queer ☐ Something else _____

Patient's Gender Identity:
☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Choose not to disclose
☐ Non-binary/genderqueer ☐ Questioning ☐ Other

Patient's sex assigned at birth: ☐ Female ☐ Male ☐ Unknown ☐ Not recorded on birth certificate
☐ Choose not to disclose ☐ Intersex

Patient's Pronouns:
☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Patient's Name ☐ Decline to Answer ☐ Unknown