NKN STUDENT HEALTH & WELLNESS CENTER

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Rinehart Clinic is the medical sponsor for NKN Student Health & Wellness Center and operates according to the guidelines set forth by Oregon Law (Oregon Revised Statutes: 109.610, 109.640, 109.675, 109.680). All services will be provided by the Rinehart Clinic health care team.

Today's date: _____

NEW PATIENT HEALTH HISTORY FORM – ADULT

PATIENT INFORMATION

Patient Name: _____ Birthdate: _____

Reason for today's visit? _____

Current Medications (Please list, including vitamins, supplements, herbs. Please note dose and quantity or bring in current medication bottles):

_____

_____

_____

Allergy to Medication(s) & Reactions? _____

Other Allergies: _____

Preferred Language: _____ Do you need an interpreter? ☐ Yes ☐ No

IMMUNIZATIONS NEEDED

☐ None – patient up to date ☐ Pneumonia ☐ Meningitis

☐ Flu ☐ Shingles ☐ HPV

☐ Tetanus/Pertussis (Whooping Cough) ☐ Hepatitis B ☐ Hepatitis A

☐ Others: _____

MEDICAL HISTORY

Do you currently have, or have a history of, any of the following conditions? (Please check all that apply.)

	Allergies		Emphysema/COPD		Myocardial Infarction
	Anemia		GERD		Nerve/Muscle Disease
	Anxiety		Glaucoma		Osteoporosis

Name: _____ DOB: _____ Date: _____

	Arthritis/Joint Disorder		Heart Disease		Seizures
	Asthma		Heart Failure		Sickle Cell Anemia
	Blood Transfusion		Heart Murmur		Stomach Ulcers
	Cancer (type):		HIV/AIDS		Stroke
	Cataracts		Hyperlipidemia		STD
	Clotting Disorder		Hypertension		Thyroid Disease
	COPD		Kidney Disease		Tuberculosis
	Depression		Liver Disease		Other:
	Diabetes		Meningitis		
Please explain any/all of the checked items:					

FAMILY MEDICAL HISTORY

Please tell us about your family's health history. Check all that apply.

Condition	Mother (Age)	Father (Age)	Brother	Sister	Other
Alive					
Deceased					
Alcohol/Drug Abuse					
Allergies					
Alzheimer's					
Anemia					
Autoimmune Disease					
Bleeding Disorder					
Cancer					
Depression					
Diabetes					
Heart Disease/Attack					
High Cholesterol					
Hypertension					

Name: _____ DOB: _____ Date: _____

Kidney Disease					
Liver Disease					
Lung Disease					
Mental Illness					
Stroke					
Suicide					
Thyroid Disease					
Other:					

PAST SURGICAL HISTORY

If you have any of the following surgeries, please write the date of the surgery next to the kind of surgery.

Surgery	**Date**	**Surgery**	**Date**	**Surgery**	**Date**
Appendectomy		C-Section		Small Intestine Surgery	
Brain Surgery		Eye Surgery		Spine Surgery	
Breast Surgery		Fracture Surgery		Tonsillectomy	
CABG		Hernia Repair		Tubal Ligation	
Cholecystectomy		Hysterectomy		Valve Replacement	
Colon Surgery		Joint Replacement		Vasectomy	
Cosmetic Surgery		Prostate Surgery		Other (describe)	

SOCIAL HISTORY

Smoking (Nicotine):

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

☐ Current Smoker ☐ Passive Smoke Exposure Types: ☐ Cigarettes ☐ Cigars ☐ Pipe

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:

If you use e-cigarettes or vaping products, please answer the following:

☐ Use every day ☐ Use some days ☐ Never used ☐ Former user. Start date: _____ Quit date: _____

Do your friends vape around you? ☐ Yes ☐ No ☐ Have you had counseling about e-cigs? ☐ Yes ☐ No

Do you use any of these substances in your device:

Nicotine ☐ Yes ☐ No THC ☐ Yes ☐ No CBD ☐ Yes ☐ No Flavoring ☐ Yes ☐ No

Other: _____

What kind of device do you use?

☐ Disposable ☐ Pre-filled or refillable cartridge ☐ Refillable Tank ☐ Pre-filled pod ☐ Other: _____

Ready to Quit? ☐ Yes ☐ No

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

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

Substance Use: ☐ Never ☐ Yes ☐ Former User (Start Date: _____ Quit Date: _____)

If yes, which kind: ☐ Amphetamines ☐ Barbiturates ☐ Benzodiazepines ☐ Cocaine ☐ Crack ☐ Ecstasy

☐ Heroin ☐ IV ☐ Ketamine ☐ LSD ☐ Marijuana ☐ Methamphetamine ☐ Mescaline

☐ Nitrous Oxide ☐ Opioids ☐ PCP ☐ Psilocybin ☐ Solvent Inhalants ☐ Vaping

☐ Other: _____ How many times per week? _____

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 ☐ Fertility Awareness

☐ Sponge ☐ Surgical ☐ Vaginal Ring ☐ Withdrawal ☐ Vasectomy ☐ None

Partners: ☐ Female ☐ Male ☐ Transgender female (M to F) ☐ Transgender male (M to F)

☐ Choose not to disclose ☐ Non-binary/genderqueer ☐ Questioning ☐ Other: _____

Name: _____ DOB: _____ Date: _____

OB/Gyn Status (for female patients):

Currently pregnant: ☐ Yes ☐ No ☐ Never pregnant

Menstrual Status: ☐ Having periods ☐ Perimenopausal ☐ Postmenopausal ☐ Other_____

Last menstrual period (date): _____ Are your periods regular? _____

# of pregnancies: ____ # of miscarriages: ____ # of abortions: ____

Are you planning to become pregnant in the next year? _____

SEXUAL ORIENTATION AND GENDER IDENTITY

What is your sexual orientation?

☐ Lesbian ☐ Straight or heterosexual ☐ Bisexual ☐ Gay ☐ Pansexual ☐ Queer ☐Omnisexual

☐ Asexual ☐ Choose not to disclose ☐ Other: _____

How do you identify in terms of gender?

☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-binary/genderqueer

☐ Questioning ☐ Two Spirit ☐ Other: _____ ☐ Choose not to disclose

What are your preferred pronouns?

☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Patient's Name ☐ Prefer Not to Answer

☐ Unknown ☐ Other: _____