NKN STUDENT HEALTH & WELLNESS CENTER

24705 US-101, Rockaway Beach, OR 97136 | Mailing Address: PO Box 176, Wheeler, OR 97147
Telephone: 503-355-3500 | Fax: 844-720-1901

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 – STUDENT

PATIENT INFORMATION

Patient Name: _____ Birthdate: _____

Name of Doctor: _____ Last Visit: _____

Name of Dentist: _____ Last Visit: _____

Allergy to Medication(s)? _____

Reason for today's visit? _____

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

IMMUNIZATIONS

Are your vaccines are up-to-date? ☐ Yes ☐ No ☐ Unsure

Have you gotten a COVID-19 Vaccine? ☐Yes ☐No ☐Unsure

If you are due for vaccines, would you like to receive vaccines today? ☐ Yes ☐ No ☐ Unsure

WELL CHILD/ANNUAL EXAM

Have you had a physical exam in the past year? ☐ Yes ☐ No ☐ Unsure

If yes, where: _____

If not, are you interested in scheduling one at NKN Student Health & Wellness Center? ☐ Yes ☐ No

MEDICAL HISTORY

Have you had any of the following conditions? (Please check all that apply.)

	Vision Problems		Serious accidents. Head trauma, concussion, or loss of consciousness.
	Allergies (Other than medication, e.g. peanuts)		Serious dental problems
	Asthma (Chronic wheeze or cough)		Depression
	Chest pain with exercise		Anxiety
	Frequent headaches		Sleep problems
	Frequent infections (ear, throat, or lung)		Serious or chronic illness like diabetes, cancer, seizures
	Missing or damaged organs (for example: Eye, kidney, testicle)		Currently taking medication

Name: _____ DOB: _____ Date: _____

	Hearing problems		Surgeries
	Problems with bowel movements		Urinary tract infection, kidney problems, bedwetting
	Learning or developmental problems		Victim of physical or sexual abuse
	Heart or blood pressure problems		Other:
	For female patients: When was your last period? _____ Are they regular? _____ Have you had a miscarriage/birth/abortion in last 12 months? _____		
Please explain any/all of the checked items:			

SOCIAL HISTORY

Who do you live with? (Please check all that apply.)

☐ Mother ☐ Father ☐ Other: _____

Who has legal custody of you? _____

Were you ever in foster care? _____

In the past year, have there been any changes in your family? (Please check all that apply.)

☐ Separation ☐ Divorce ☐ Birth ☐ Loss of job

☐ Change to new school ☐ Serious Illness

☐ Any other changes/stresses? _____

Are you sexually active? _____

Habits: (Please check all that apply)

☐ 30 minutes of exercise most days

☐ 5 servings of fruits & vegetables most days

☐ Caffeine ☐ Tobacco ☐ Alcohol

☐ Recreational Drugs

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 ☐ He/Him ☐ They/Them ☐ Patient's Name

☐ Prefer Not to Answer ☐ Unknown ☐ Other _____

FAMILY MEDICAL HISTORY

Do any members of your family have any of the following? Please explain who in the family next to the health issue (mother, father, sister, brother, aunt, uncle, grandparent).

	Alcohol or drug use
	Allergies
	Asthma
	Blood problems
	Diabetes
	Death (age 45 or younger)
	Heart problems
	High blood pressure
	Mental illness
	Obesity
	Seizures
	Other: