



NKN STUDENT HEALTH & WELLNESS CENTER

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Nehalem Bay Health Center (formerly known as 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 Nehalem Bay Health Center 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

- | | | |
|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> None – patient up to date | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Flu | <input type="checkbox"/> Shingles | <input type="checkbox"/> HPV |
| <input type="checkbox"/> Tetanus/Pertussis (Whooping Cough) | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Others: _____ | | <input type="checkbox"/> Not sure |

MEDICAL HISTORY

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

<input type="checkbox"/> Allergies	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Anemia	<input type="checkbox"/> GERD	<input type="checkbox"/> Nerve/Muscle Disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Osteoporosis

Name: _____

DOB: _____

Date: _____

<input type="checkbox"/>	Arthritis/Joint Disorder	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Stomach Ulcers
<input type="checkbox"/>	Cancer (type):	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Hyperlipidemia	<input type="checkbox"/>	STD
<input type="checkbox"/>	Clotting Disorder	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	COPD	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	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					
Kidney Disease					

Name: _____

DOB: _____

Date: _____

Condition	Mother (Age)	Father (Age)	Brother	Sister	Other
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 (F to M)

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: _____