NKN STUDENT HEALTH & WELLNESS CENTER

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Telephone: 503-355-3500 | Fax: 844-720-1901

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 Nehalem Bay Health Center 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: