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

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

☐ None – patient up to date ☐ Pneumonia ☐ Meningitis
☐ Flu ☐ Shingles ☐ HPV
☐ Tetanus/Pertussis (Whooping Cough) ☐ Hepatitis B ☐ Hepatitis A
☐ Others: ____ ☐ Not sure

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

Other Surgery (please describe) ____

SOCIAL HISTORY

Smoking (Nicotine):

☐ 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:

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 sex were you assigned at birth? ☐ Female ☐ Male ☐ Unknown ☐ Not recorded on birth certificate

☐ Choose not to disclose ☐ Intersex

What are your preferred pronouns?

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

☐ Unknown ☐ Other: ____