



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 follows Oregon law (ORS 109.640, 109.675) which permits minors age 15 and older to consent to medical and dental care, and minors 14 and older to consent to outpatient mental health or substance use treatment without a parent or guardian. Minors at any age may sign their own consent to access reproductive health services. While we encourage parental involvement and may notify parents when clinically appropriate (ORS 109.650, 109.680), we also ensure that student health records remain confidential and are only shared with school staff as permitted by law or with specific written authorization.

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 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: _____

<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	Surgeries
<input type="checkbox"/>	Problems with bowel movements	<input type="checkbox"/>	Urinary tract infection, kidney problems, bedwetting
<input type="checkbox"/>	Learning or developmental problems	<input type="checkbox"/>	Victim of physical or sexual abuse
<input type="checkbox"/>	Heart or blood pressure problems	<input type="checkbox"/>	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).

<input type="checkbox"/>	Alcohol or drug use
<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Blood problems
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Death (age 45 or younger)
<input type="checkbox"/>	Heart problems
<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Mental illness
<input type="checkbox"/>	Obesity
<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Other: