orchidhealth
*Exceptional, local healthcare*

## Comprehensive New Patient Health History – Adult

**Name _____ Date of Birth ___/___/_____ Gender ___**

**Did anyone assist you with completing this form? Yes/No If yes, who?_____**

**Current Medical Concerns (what you would like to talk about today):**

**1. (most important) _____**

**2. _____**

**3. _____**

**Have you received the following IMMUNIZATIONS (SHOTS?) ? If yes, then please try to indicate the approximate year it was given:**

**Influenza** No ☐ Yes ☐ **Year _____**
**Hepatitis A** No ☐ Yes ☐ **Year _____**
**Hepatitis B** No ☐ Yes ☐ **Year _____**
**Polio** No ☐ Yes ☐ **Year _____**
**Other (please specify)** No ☐ Yes ☐ **Year _____**
**Tetanus/Diphtheria** No ☐ Yes ☐ **Yr _____**
**Shingles Vaccine** No ☐ Yes ☐ **Yr _____**
**MMR (Measles/Mumps/Rubella)** No ☐ Yes ☐ **Yr_____**
**Pneumonia Shot** No ☐ Yes ☐ **Yr _____**

**Please list any ALLERGIES you have to medications:**

| NAME OF MED | Reaction |
|---|---|
| | |
| | |

**Please list any MEDICATIONS that you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins:**

| NAME OF MED | Dose | Directions (How often you take it) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Do you have DIFFICULTY performing any of these activities by YOURSELF?**

| | | | | | |
|---|---|---|---|---|---|
| **Eating** | No ☐ Yes ☐ | **Walking** | No ☐ Yes ☐ | **Dressing** | No ☐ Yes ☐ |
| **Bathing** | No ☐ Yes ☐ | **Using Toilet** | No ☐ Yes ☐ | **Housekeeping** | No ☐ Yes ☐ |
| **Errands** | No ☐ Yes ☐ | **Driving** | No ☐ Yes ☐ | **Managing Money** | No ☐ Yes ☐ |

orchidhealth
*Exceptional, local healthcare*

## Family Health History

### Are you adopted? Yes / No (If NO, please complete section below)

| | Father | Mother | Grandmother | Grandfather | Brother | Sister | Aunt | Uncle |
|---|---|---|---|---|---|---|---|---|
| **ADHD** | | | | | | | | |
| **Alzheimer's Disease** | | | | | | | | |
| **Alcoholism** | | | | | | | | |
| **Aneurysm** | | | | | | | | |
| **Anxiety or Depression** | | | | | | | | |
| **Arthritis** | | | | | | | | |
| **Asthma** | | | | | | | | |
| **Blood Disorder** | | | | | | | | |
| **Cancer** | | | | | | | | |
| **Diabetes** | | | | | | | | |
| **Emphysema/COPD** | | | | | | | | |
| **Hereditary Disorder** | | | | | | | | |
| **High Cholesterol** | | | | | | | | |
| **High Blood Pressure** | | | | | | | | |
| **Kidney Disease** | | | | | | | | |
| **Liver Disease** | | | | | | | | |
| **Manic-Depression or Bipola** | | | | | | | | |
| **Migraines** | | | | | | | | |
| **MI = Heart Attack** | | | | | | | | |
| **Osteoporosis** | | | | | | | | |
| **Seizures** | | | | | | | | |
| **Skin Cancer** | | | | | | | | |
| **Stroke** | | | | | | | | |
| **Sudden Cardiac Death** | | | | | | | | |
| **Thyroid Disorder** | | | | | | | | |

orchidhealth
*Exceptional, local healthcare*

## Personal Health History

| | | | | | |
|---|---|---|---|---|---|
| **ADHD or ADD** | **No ☐** | **Yes ☐** | **Endometriosis** | **No ☐** | **Yes ☐** |
| **Allergies/Hayfever** | **No ☐** | **Yes ☐** | **Fibromyalgia** | **No ☐** | **Yes ☐** |
| **Anemia** | **No ☐** | **Yes ☐** | **Gout** | **No ☐** | **Yes ☐** |
| **Anesthesia Complications** | **No ☐** | **Yes ☐** | **GYN Problems** | **No ☐** | **Yes ☐** |
| **Anxiety Disorder or Recurrent Anxiet** | **No ☐** | **Yes ☐** | **HIV** | **No ☐** | **Yes ☐** |
| **Arthritis** | **No ☐** | **Yes ☐** | **Heart Problems** | **No ☐** | **Yes ☐** |
| **Asthma** | **No ☐** | **Yes ☐** | **Hepatitis C** | **No ☐** | **Yes ☐** |
| **Autism Spectrum Disorder** | **No ☐** | **Yes ☐** | **High Blood Pressure/Hypertensio** | **No ☐** | **Yes ☐** |
| **Bipolar or Schizophrenia** | **No ☐** | **Yes ☐** | **High Cholesterol** | **No ☐** | **Yes ☐** |
| **Birth Defects or Inherited Disease** | **No ☐** | **Yes ☐** | **Kidney Stones** | **No ☐** | **Yes ☐** |
| **Blood Transfusion** | **No ☐** | **Yes ☐** | **Kidney or Bladder Problems** | **No ☐** | **Yes ☐** |
| **Cancer** | **No ☐** | **Yes ☐** | **Liver Disease** | **No ☐** | **Yes ☐** |
| **Chicken Pox** | **No ☐** | **Yes ☐** | **Migraines** | **No ☐** | **Yes ☐** |
| **Clotting Problems - Bleed too much c History of Blood Clots** | **No ☐** | **Yes ☐** | **Muscle, Joint, or Bone Problems** | **No ☐** | **Yes ☐** |
| **Depression** | **No ☐** | **Yes ☐** | **Osteoporosis** | **No ☐** | **Yes ☐** |
| **Developmental or Behavioral Disorde** | **No ☐** | **Yes ☐** | **Reflux/GERD** | **No ☐** | **Yes ☐** |
| **Diabetes or Pre-Diabetes** | **No ☐** | **Yes ☐** | **Seizures/Epilepsy** | **No ☐** | **Yes ☐** |
| **Diverticulitis/Diverticulosis** | **No ☐** | **Yes ☐** | **Skin problems (Rashes/Changing Moles)** | **No ☐** | **Yes ☐** |
| **Domestic Violence** | **No ☐** | **Yes ☐** | **Stomach Ulcers or Swallowing Problems** | **No ☐** | **Yes ☐** |
| **Ear Infections - Chronic** | **No ☐** | **Yes ☐** | **Stroke or TIA** | **No ☐** | **Yes ☐** |
| **Ear or Hearing Problems** | **No ☐** | **Yes ☐** | **Thyroid Problems** | **No ☐** | **Yes ☐** |
| **Eating Disorder like Anorexia or Bulii** | **No ☐** | **Yes ☐** | **Tuberculosis or Positive TB Test** | **No ☐** | **Yes ☐** |
| **Eczema** | **No ☐** | **Yes ☐** | **Vision or Eye Problems** | **No ☐** | **Yes ☐** |
| **Emphysema/COPD/Chronic Bronchit** | **No ☐** | **Yes ☐** | **Other: _____** | **No ☐** | **Yes ☐** |

orchidhealth
*Exceptional, local healthcare*

**Have you ever had surgery? No ☐ Yes ☐**
**If YES, please list your surgeries (include the year if possible):**

_____

_____

**Have you stayed overnight in the hospital for other problems? No ☐ Yes ☐**
**If YES, please list them (include the year if possible):**

_____

_____

**Have you ever had any other serious injuries or broken bones? No ☐ Yes ☐**
**If YES, please list them (include the year if possible):**

_____

_____

**Have you had any of these TESTS? If yes, then please indicate when:**

**Colonoscopy No ☐ Yes ☐ Year _____** **Bone Density Test No ☐ Yes ☐ Year _____**
**Pap Smear No ☐ Yes ☐ Year _____** **Mammogram No ☐ Yes ☐ Year _____**
**Heart Testing/Stress Test No ☐ Yes ☐ Year _____**

## Social Health History

**Relationship Status: Married / Divorced / Widow(er) / Single / Other Partner**

**What is your current living arrangement? House Apartment Care Home Other_____**

**Do you live: ALONE With Spouse/Family With Others:_____**

**Do you feel safe at home? No ☐ Yes ☐**

**Is there somewhere else you feel unsafe? No ☐ Yes ☐**

**Do you have concerns about meeting basic needs (food/clothing/shelter?) No ☐ Yes ☐**

**Do you have have to follow a special diet? Yes/No If Yes, describe:_____**

**Education: What is your highest level of education? (What grade did you finish in school, or what degre after High School?) _____**

**Occupation: Current Employment Status - Working / Unemployed / Retired / Intentionally Unemployed**
**Type of Work _____**

orchidhealth
*Exceptional, local healthcare*

**Disability: Are you disabled? Yes / No** _____

**Incarceration: Have you ever been incarcerated? Yes / No If yes, please specify**_____

**Do you Smoke? Yes / No Do you use any other forms of Tobacco? Yes / No**

**How many times in the past year have you had heavy alcohol consumption? (5+ drinks for men, 4+ for women in one day)?**

**Never 1 or more**

**How many times in the past year have you used an illegal drug OR used a prescription drug for non-medical reasons?**

**Never 1 or more**

**How do you think of your Overall Health? ❒ excellent ❒ good ❒ fair ❒ poor**

**Have you ever been diagnosed with Depression or Anxiety? No ☐ Yes ☐**

**During the past TWO WEEKS, have you often been bothered by of the following problems?**

- **Feeling down, depressed, irritable or hopeless? No ☐ Yes ☐**
- **Little interest or pleasure in doing things? No ☐ Yes ☐**

**WOMEN: Is there a chance you are pregnant? No ☐ Yes ☐**

**Have you been pregnant before? No ☐ Yes ☐ (How many times?)**_____

**When was your last menstrual period?** _____

**Is there anything else we have missed that you feel we should know about your health?**

_____

_____

**Thank you!**