orchidhealth
Exceptional, local healthcare

New Patient Health History – Adult

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

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

_____

_____

Please list any allergies you have to medications:

_____

_____

Please list any medications you currently take, including over the counter medications, supplements, or vitamins:

_____

_____

Have you received any immunizations outside of Oregon? If so, where? _____

FEMALES: Is there a chance you are pregnant? ❒ Yes ❒ No

Have you been pregnant before? ❒ Yes ❒ No (How many times?) ___

Have you been to the hospital multiple times for the same issue in the last 2 years?

❒ Yes ❒ No If yes, please explain below:

_____

_____

Have you ever had surgery? ❒ Yes ❒ No If YES, please list them (include the year if possible):

_____

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

_____

Have you had any of these tests? If YES, please indicate when:

Colonoscopy: ❒ Yes ❒ No Year _____ Bone Density Test: ❒ Yes ❒ No Year _____

Pap Smear: ❒ Yes ❒ No Year _____ Mammogram: ❒ Yes ❒ No Year _____

Please list health conditions that your family members have:

_____

_____

Please list your health conditions:

_____

_____

Do you or have you ever smoked tobacco? ❒ Yes ❒ No

How Many Years did you smoke tobacco? _____

Do you use or have you used other forms of tobacco, like chewing tobacco? ❒ Yes ❒ No

Do you use e-cigarettes (vape)? ❒ Yes ❒ No