

Adult Health History

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all five pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

PATIENT NAME	DATE	AGE
Main reason for today's visit: _____		
Other concerns: _____		
What are your health goals for the next year? _____		
Where were you getting your healthcare before? _____		

In the past two weeks, have you been bothered by:

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

REVIEW OF SYMPTOMS

Please check any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

GENERAL

- ☐ Unexplained weight loss / gain
- ☐ Unexplained fatigue / weakness
- ☐ Fall asleep when sitting, day
- ☐ Fever or chills
- ☐ NO problems

SKIN

- ☐ New or change in mole
- ☐ Rash / itching
- ☐ NO problems

BREAST

- ☐ Breast lump, pain, nipple discharge
- ☐ NO problems

EARS/NOSE/THROAT

- ☐ Nosebleeds, trouble swallowing
- ☐ Frequent sore throats, hoarseness
- ☐ Hearing loss / ringing in ears
- ☐ NO problems

EYES

- ☐ Change in vision / eye pain / redness
- ☐ NO problems

CARDIOVASCULAR

- ☐ Chest pain / discomfort
- ☐ Palpitations (fast or irregular heartbeat)
- ☐ NO problems

RESPIRATORY

- ☐ Cough / wheeze
- ☐ Loud snoring / altered breath
- ☐ Shortness of breath w/ exertion
- ☐ NO problems

GASTROINTESTINAL

- ☐ Heartburn / reflux / indigestion
- ☐ Blood or change in bowel movement
- ☐ Constipation
- ☐ NO problems

GENITOURINARY

- ☐ Leaking urine
☐ Blood in urine
☐ Nighttime urination or increased frequency
☐ Discharge: penis or vagina
☐ Concern w/ sexual function
☐ **NO problems**

MUSCULOSKELETAL

- ☐ Neck pain
☐ Back pain
☐ Muscle / joint pain
☐ NO problems

ENDOCRINE

- ☐ Heat or cold sensitivity
☐ NO problems

HEMATOLOGIC/LYMPHATIC

- ☐ Swollen glands
☐ Easy bruising
☐ NO problems

NEUROLOGICAL

- ☐ Headache
☐ Memory loss
☐ Fainting
☐ Dizziness
☐ Numbness / tingling
☐ Unsteady gait
☐ Frequent falls
☐ NO problems

ALLERGIC / IMMUNE

- ☐ Hay fever / allergies
☐ Frequent infections
☐ NO problems

PSYCHIATRIC

- ☐ Anxiety / stress / irritability
☐ Sleep problems
☐ Lack of concentration
☐ NO problems

WOMEN ONLY

- ☐ Premenstrual symptoms (bloating, cramps, irritability)
☐ Problem with menstrual periods
☐ Hot flashes / night sweats
☐ NO problems

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known.

Check this box if you don't know the information: ☐

- | | |
|--|--|
| ☐ Tetanus (Td) _____ | ☐ Tetanus w/ Pertussis (Tdap) _____ |
| ☐ Varicella (Chicken Pox) shot or illness _____ | ☐ Pneumovax _____ |
| ☐ Influenza (flu shot) _____ | ☐ Hepatitis A _____ |
| ☐ Hepatitis B _____ | ☐ MMR _____ |
| ☐ Zostavax (shingles) _____ | ☐ HPV _____ |

WOMEN'S HEALTH HISTORY

Total number of pregnancies _____

Date of last menstrual period (if still menstruating) _____

Age at beginning of periods _____

Age at end of periods (menopause) _____

MEDICATIONS

Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. ☐ I take no medications

MEDICATION	DOSE (e.g. mg/pill)	HOW MANY TIMES PER DAY?

Any allergies or intolerance to medications (include type of reaction)?:

☐ I have no allergies

PERSONAL MEDICAL HISTORY: Do you have (now) or have you had (past) any of the following conditions? ☐ NON

Condition	Now	Past	Comments
Alcohol / Drug use			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema			
Fractures (broken bones)			WHERE?:
Gallbladder Disease			
Gastroesophageal Reflux			
Glaucoma			

Condition	Now	Past	Comments
Gout			
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (Eczema)			
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) /			
Thyroid Low (Underactive) /			
Other (list)			
Other (list)			

SURGICAL HISTORY: Please check off any procedure or surgeries. List any abnormal findings or complications.

Surgical Procedure	No	Yes	Year	Comments
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy				Circle: Right Left Both
Breast Surgery				Circle: Right Left Both
Colonoscopy				

Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				Circle: Laparoscopic
Heart Surgery (other than coronary bypass)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal

SURGICAL HISTORY

Knee Surgery		Continued: Surgical Procedure	Circle: Right Left Both	No	Yes
LEEP (Cervix Surgery)		Neck Surgery			
Neck Surgery		LEEP (Cervix Surgery)			
Ovary Ligation ("Tubal")		Neck Surgery			
Ovary Removal		Ovary Ligation ("Tubal")	Circle: Right Left Both		
Vasectomy		Ovary Removal			
Sigmoidscopy		Vasectomy			
Sinus Surgery		Sigmoidscopy			
Other (list)		Sinus Surgery			
		Other (list)			

Are you adopted? ☐ Yes* ☐ No

*If yes, and you do NOT know your family history, please skip to section "Other Health Issues".

DISEASE	MOTHER	FATHER	SISTER(S)	BROTHER(S)	MOM'S	MOM'S DAD	DAD'S MOM	DAD'S DAD	OTHER RELATIVES	COMMENTS
No significant history known										
Alcohol / Drug abuse										
Allergic Disorder										
Cancer										
Diabetes										
Gastrointestinal Disorder										
Heart Disease										
Hypertension										
Kidney Disease										
Mental Illness										
Migraine Headache										
Myocardial Disorder										
Respiratory Disorder										
Seizure Disorder										
Stroke Syndrome										
Tuberculosis										

OTHER HEALTH ISSUES

Tobacco Use

Smoke cigarettes: ☐ Yes ☐ No

☐ Never (If you never smoked, please skip to alcohol section)

Quit Date:

How many years did you smoke? _____

How many packs a day did you smoke? _____

Current smoker:

Packs per day: _____

Number of years: _____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff

☐ Chew

Alcohol Use

Do you drink alcohol?

☐ Yes ☐ No

Number of drinks per week: _____

☐ Beer ☐ Wine ☐ Liquor

Drug Use

Do you use marijuana or recreational drugs?

☐ Yes ☐ No

Have you ever used needles to inject drugs?

☐ Yes ☐ No

Sexual Activity

Sexually involved currently?

☐ Yes ☐ No

Sexual partners have been:

☐ Male ☐ Female

Birth control method (circle all that apply):

Condom, pill, diaphragm, vasectomy, other

Have you completed any of the following: (please check all that apply)

☐ Advance Directive for Healthcare (ADHC) ☐ Living Will

☐ POLST (Physician Orders for Life Sustaining Therapy)

Exercise

Do you exercise regularly?

☐ Yes ☐ No

What kind of exercise?

How long (minutes): _____

How often: _____

Diet

How would you rate your diet?

☐ Good ☐ Fair ☐ Poor

Would you like advice on your diet?

☐ Yes ☐ No

Safety

Do you use a bike helmet?

☐ Yes ☐ No ☐ No bike

Do you use seatbelts consistently?

☐ Yes ☐ No

Does your home have a working smoke detector?

☐ Yes ☐ No

If you have guns in your home, are they locked up?

☐ Yes ☐ No ☐ Not applicable

Is violence in your home a concern for you?

☐ Yes ☐ No

SOCIAL HISTORY

Occupation (or prior occupation): _____

If not currently employed, please circle one:

☐ Retired ☐ Unemployed ☐ Leave of absence ☐ Disabled

Employer: _____

Years of education or highest degree: _____

Marital status (please check one):

☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Spouse/partner name: _____

Number of children: _____

Age(s) if under 18 years: _____

Number of grand children: _____

Number of great grandchildren: _____

Who lives at home with you?

Leisure activities, group involvement, religion, volunteer work, recent travel:



For Internal Use Only: MRN _____

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME _____
Last First Middle

PREVIOUS NAME(S) _____ GENDER: M ___ F ___

STREET ADDRESS /
P.O. BOX _____

CITY _____ STATE _____ ZIP CODE _____

PHONE NUMBER _____ EMAIL _____

DATE OF BIRTH _____ (MM) _____ (DD) _____ (YYYY)

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that “a person who is a recipient of Medicaid or insurance pursuant to the Children’s Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically” (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient’s responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

Signature of patient or authorized representative

Date

Time

If I sign this form as the Patient’s Authorized Representative, I understand that all references in this form to “I”, “me” or “my” refer to the Patient.

Name of Authorized Representative (Printed)

Relationship

Date

Time

Address of authorized representative signing this form (please print):

Phone number of authorized representative

FOR INTERNAL USE ONLY

Name of Organization: _____ Name of Witness: _____

As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in health care.

Patient Consent Form for Electronic Exchange of Individual Health Information



HealthHIE Nevada is a non-profit organization dedicated to connecting the healthcare community to share information electronically and securely to improve the quality of healthcare services. To learn more about the Health Information Exchange (HIE), read the Patient Information brochure. You can ask the doctor that gave you this form for it, or go to the website www.healthHIENevada.org.

Details about patient information in HealthHIE Nevada and the consent process:

1. **How your information will be used and who can access it:** When you provide consent, only HealthHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers, and pharmacies), will have access to your health information. It can only be used to:
 - Provide you with medical treatment and related services.
 - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information.
2. **Types of information included and where it comes from:** The information about you comes from organizations that have provided you with medical care, and are HealthHIE Nevada participants. These may include hospitals, physicians, pharmacies, clinical laboratories, and other healthcare organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this Consent Form. This information may relate to sensitive health conditions, including but not limited to:
 - Alcohol or drug use problems
 - HIV/AIDS
 - Birth control and abortion (family planning)
 - Genetic (inherited) diseases or tests
 - Mental health conditions
 - Sexually transmitted diseases
3. **Improper Access or Disclosure of your Information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada State Law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.
4. **Effective Period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealthHIE Nevada ceases to conduct business.
5. **Revoking your consent:** At any time, you may revoke your consent by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

Note: Organizations that access your health information through HealthHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. **How your information is protected:** Federal and State laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada State law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

Copy of Form: You are entitled to receive a copy of this Consent Form after you sign it.