

p. 1	Name: _____	DOB: _____	Date: _____
To access your Medical Record from the electronic patient portal please provide your current email address to receive an invitation: _____			

Previous health care provider: _____ Last seen: ___/___/___ Last physical exam: ___/___/___
 Specialist names within last year (Include mental health) _____ Last seen: ___/___/___
 Medical Equipment Services to include company names _____
 Hospital stays/ER visits within last year? No *or*-Where _____ When _____ How many _____

MEDICATIONS (MEDICATIONS TAKEN REGULARLY, INCLUDE OVER THE COUNTER, & HERBAL)

Were you referred to us? If so, who referred you? _____	Yes	No
Are you taking any prescribed, over the counter, or herbal medicines? Please list each below.	Yes	No
<i>Medication Name</i>	<i>Dose</i>	<i>How often taken</i>

PREFERRED PHARMACY: _____

SECONDARY PHARMACY: _____

List Medication Allergies	Describe Reaction to Medication(s)	List Food/Other Allergies	Describe Reaction to Food/Other
1. _____		1. _____	
2. _____		2. _____	
3. _____		3. _____	

LEARNING NEEDS AND HEALTH LITERACY ASSESSMENT

What languages do you speak?	___ English	___ Spanish	___ Marshallese	___ Other	
What languages do you read?	___ English	___ Spanish	___ Marshallese	___ Other	
What is your highest level of education?	___ Grade 1-6	___ Grade 7-12	___ College	___ None	
How do you prefer to learn?	___ Person to person	___ Hand-outs	___ Audio/Visual	___ Other	
Do you have any special educational needs we should be aware of in the following areas: (___ Hearing) (___ Sight) (___ Speech) (___ Spiritual) (___ Cultural beliefs)					
At this time, do you have any limitations or emotional barriers that may affect your ability to learn?				Yes	No
When you are given instructions from your doctor or pharmacist, how often do you need to have someone help you? (___ Never) (___ Rarely) (___ Sometimes) (___ Often) (___ Always)					
Do you have trouble doing any of the following for yourself? <input type="checkbox"/> Bathing <input type="checkbox"/> Shopping <input type="checkbox"/> Dressing <input type="checkbox"/> Feeding					

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Please circle Yes or No)

High Blood Pressure	Yes	No	Positive TB skin test	Yes	No
Heart disease	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Blood transfusions	Yes	No
High cholesterol	Yes	No	HIV/AIDS	Yes	No
Cancer	Yes	No	Epilepsy	Yes	No
Kidney disease	Yes	No	*Mental health concern	Yes	No
Hepatitis	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	Other conditions	Yes	No

Please list other diagnosis(es) or conditions: _____

Specific past Surgeries, please indicate date	Other (please explain)	___/___/___
Hysterectomy	___/___/___	Tubal Ligation
Mastectomy (Unilateral: L/R or Bilateral)	___/___/___	Colectomy
*Have you ever had an experience so upsetting it caused nightmares, avoidance, or disconnection from others? Yes No		
Have you had any falls, trauma or other injury? Yes No		
What is your usual diet? <input type="checkbox"/> Regular <input type="checkbox"/> Low salt <input type="checkbox"/> ADA <input type="checkbox"/> Low cholesterol <input type="checkbox"/> Vegetarian <input type="checkbox"/> Other		

p. 2	Name:	DOB:
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Have you lost significant weight recently?				Yes	No	Are you currently employed?				Yes	No		
What is your occupation?						Do you live alone?						Yes	No
Do your daily activities require you to stay in the sun?				Yes	No	Have you ever been exposed to asbestos, radiation, chemicals, or fumes?				Yes	No		
Do you wear your seatbelt?				Yes	No	Do you have a smoke detector at home?				Yes	No		
FAMILY MEDICAL HISTORY <i>(Please circle)</i>	Mother		Father		Sister(s)		Brother(s)		Grandparents/other				
	Living	Deceased	Living	Deceased	Living	Deceased	Living	Deceased	Living	Deceased			
Cancer	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
High Cholesterol	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Diabetes	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Heart Disease	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Hypertension	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
ADD/ADHD	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Allergies	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Arthritis	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Asthma	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Bleeding/Clotting Disorders	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Cystic Fibrosis	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Depression	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Early Deaths	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Genetic Disease	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Headache	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Hepatitis	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
HIV Infection	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Kidney Disease	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Psychiatric	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Seizure Disorder	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Sickle Cell Abnormality	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Stroke	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Thyroid Disorder	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Tuberculosis	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			

WOMEN'S HEALTH

Start date of last menstrual period?	/ /	Have you begun menopause?	Yes	No	
Any menstrual problems or recent changes	Yes/No	Last pap smear?	/ /	Last mammogram?	/ /
How many times have you been pregnant?		How many miscarriage(s) have you had?			
How many full-term pregnancies have you had?		How many ectopic pregnancies have you had?			
How many premature pregnancies have you had?		How many of your children are living?			
How many abortions have you had?		Satisfied w/current contraceptive method?	Yes	No	

SEXUAL ORIENTATION AND GENDER IDENTITY

Sexual Orientation: <input type="checkbox"/> Straight <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Decline
Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender: Male to Female <input type="checkbox"/> Transgender: Female to Male <input type="checkbox"/> Genderqueer <input type="checkbox"/> Other <input type="checkbox"/> Decline

This form is only to assist our staff in information gathering. Information will be extracted from this form and summarized in your electronic Medical Record.

p. 3	Name:	DOB:
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REVIEW OF SYSTEMS (symptoms that you have had recently) (Please circle Yes or No) (*Initiate WHO)

Vision loss/disturbance	Yes	No	Blood in the stool	Yes	No	Weakness	Yes	No
Eye pain/redness	Yes	No	Pain/burning with urination	Yes	No	Numbness	Yes	No
Frequent nosebleeds	Yes	No	Frequent urination	Yes	No	Abnormal sensations	Yes	No
Hearing loss	Yes	No	Blood in urine	Yes	No	Intolerance to cold/heat (circle)	Yes	No
Hoarseness	Yes	No	Incontinence	Yes	No	Excessive Sweating	Yes	No
Snoring nightly	Yes	No	Frequent nighttime urination	Yes	No	Trouble/pain in teeth/mouth	Yes	No
Shortness of breath	Yes	No	Excessive urination	Yes	No	Fatigue	Yes	No
Cough	Yes	No	Excessive thirst	Yes	No	Trouble sleeping	Yes	No
Wheezing	Yes	No	Excessive hunger	Yes	No	*Depressed feelings	Yes	No
Fever or chills	Yes	No	Chest pain	Yes	No	*Anxious feelings/racing thoughts	Yes	No
Loss of appetite	Yes	No	Fluttering/palpitations in chest	Yes	No	*Thoughts: hurting/killing self/others	Yes	No
Weight gain/loss (circle)	Yes	No	Passing out	Yes	No	Worrisome/changing moles	Yes	No
Nausea	Yes	No	Swelling in legs	Yes	No	Females: painful periods	Yes	No
Vomiting	Yes	No	Joint pain	Yes	No	Females: heavy periods	Yes	No
Abdominal pain	Yes	No	Joint stiffness/swelling	Yes	No	Females: irregular periods	Yes	No
Diarrhea	Yes	No	Rash	Yes	No	Females: vaginal discharge	Yes	No
Constipation/Irregularity	Yes	No	Blood Clots	Yes	No	Males: discharge from penis	Yes	No
Heartburn	Yes	No	Easy/unusual bruising/bleeding	Yes	No	Males: pain in testicle(s)	Yes	No
Painful/difficult swallowing	Yes	No	Swollen lymph nodes	Yes	No	Males: swelling or lump in testicle(s)	Yes	No
Feeling full early in a meal	Yes	No	Headache	Yes	No	Males: difficulty starting urination	Yes	No

At HICHC, we care about your health. Please take a few minutes to complete these annual screening questions.

1. Do you currently use any nicotine or tobacco products? (Including cigarettes, chewing tobacco, e-cigarettes)	Yes	No
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During the last 2 weeks , have you been bothered by:			(staff use)
2. Little interest or pleasure in doing things	YES	NO	(any +)
3. Feeling down, depressed, or hopeless	YES	NO	PHQ-9
4. Feeling worried, tense, or anxious	YES	NO	GAD-7

During the last 12 months , have you:			(staff use)
5. Used marijuana	YES	NO	(any +)
6. Used other drugs	YES	NO	DAST-10
7. Misused prescriptions drugs (took more than prescribed, someone else's, etc.)	YES	NO	

For the following questions, 1 standard drink = 12oz beer, 8-9oz malt liquor, 4-5oz wine, or 1oz shot of hard liquor.

	0	1	2	3	4	(Audit-C 3+WHO)
8. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
9. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
10. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

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