NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
HEALTH HISTORY

(All information is strictly confidential)

Patient Name: Today's Date: / /

Date of Birth: / /

Which pharmacy do you use?

Address or cross streets: Phone number:

For patients 18 and up, do you have an Advanced Directive/Living Will in place? ☐ YES ☐ NO
If so, would you like to keep a copy on file with us? ☐ YES ☐ NO

What is the primary reason for your visit today?

When was your last mammogram? / / What were the results?

When was your last pap smear? / / Was it normal? ☐ YES ☐ NO

When was your last colon cancer screening? / / What were the results?

For diabetic patients only, when was the last time you had an eye exam? / /

Are you currently experiencing any pain today? ☐ YES ☐ NO
If you answered yes to the previous question, how would you rate your pain right now on a scale of 0-10? _____

For females only, when was the first day of your last menstrual cycle? / /

For patients aged 65 and up, have you had any falls in the past year? ☐ YES ☐ NO
If you answered yes to the previous question, how many falls have you had in the past year? _____
Did those falls result in injury? ☐ YES ☐ NO

Please list any medications (prescription & over the counter), supplements, or vitamins that you take:
(If you brought your medication list with you today, then please provide list to front office staff to copy and do not complete this section)

Medication Name	Strength	How often do you take it?

Please list any allergies:

Allergy	Reaction

Please check (✕) if you have recently been experiencing any of the following symptoms:

☐ Chills	☐ Fatigue	☐ Fever	☐ Unintentional weight loss	☐ Cough
☐ Shortness of breath	☐ Wheezing	☐ Chest pain	☐ Swelling of lower legs (edema)	☐ Abdominal pain
☐ Constipation	☐ Diarrhea	☐ Nausea	☐ Vomiting	

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Check one answer for each question.

Little interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

(All information is strictly confidential)

Please check (✕) any medical conditions you currently have or have had in the past:

☐ Arthritis	☐ Asthma	☐ Blood clots	☐ COPD	☐ Depression
☐ Diabetes	☐ High cholesterol	☐ Heart disease	☐ Hepatitis/liver disease	☐ HIV
☐ High blood pressure	☐ Heart attack	☐ Kidney disease	☐ Stroke	☐ Thyroid disease
☐ Cancer:				
☐ Other:				

Please list any surgeries you have had in the past:

Surgery	Approximate Year Performed

Please list your family medical conditions:

Family Member	Are They Living?	Medical Conditions
Mother	☐ YES ☐ NO	
Father	☐ YES ☐ NO	
Sister(s)	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
Brother(s)	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	

Are you currently, or have you ever been a tobacco user? ☐ YES ☐ NO ☐ FORMERLY

If yes or formerly, what type of tobacco? _____

How much/often do or did you use? _____

If a former tobacco user, what age were you when you quit? _____

Do you consume alcohol? ☐ YES ☐ NO ☐ FORMERLY

If so, what type? _____

How often do you drink? ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially

How much do you drink when you do? _____

When was your last drink? _____

I certify that the above information is correct to the best of my knowledge.

_____ _____

Signature Date

_____ _____

Reviewed by Date