New Patient
Medical History Form

Nebraska Urban Indian
Medical Center

Name : ____________________ Date: ____________

Birth Date : ____________________ Age: ____________

ALLERGIES

☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information .

HEALTH MAINTENANCE SCREENING TEST HISTORY

Cholesterol	Date:	Where:	Abnormal Result? Y N
Colonoscopy	Date:	Where:	Abnormal Result? Y N
Mammogram	Date:	Where:	Abnormal Result? Y N
Pap Smear	Date:	Where:	Abnormal Result? Y N
Bone Density	Date:	Where:	Abnormal Result? Y N

VACCINATION HISTORY *if known*

Last Tetanus Booster or TdaP:	Last Pnuemovax (*Pneumonia*):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine (*Shingles*):	

If patient is a child, are they up to date with vaccines:? Yes No

PERSONAL MEDICAL HISTORY

☐ None

Alcohol or Drug Problem	Y N	Heart Murmur	Y N
Abdominal Pain	Y N	Hepatitis B	Y N
Allergies (Hay Fever)	Y N	Hepatitis C	Y N
Anemia	Y N	HIV/AIDS	Y N
Angina (Chest Pain)	Y N	High Cholesterol (Hyperlipidemia)	Y N
Arthritis	Y N	High Blood Pressure (Hypertension)	Y N
Asthma	Y N	Kidney Problems	Y N
Atrial Fibrillation	Y N	Liver Disease	Y N
Back Pain	Y N	Lung Problems (COPD, Emphysema)	Y N
Bleeding Disorder (Hemophilia)	Y N	Osteoporosis or Osteopenia	Y N
Blood Clots	Y N	Panic Attack or Anxiety	Y N
Cancer (Specify Type)	Y N	PTSD	Y N
Colon or Bowel Disease (Polyps)	Y N	Seizures (Epilepsy)	Y N
Diabetes	Y N	Sickle Cell Disease	Y N
Depression	Y N	Sleep Apnea	Y N
Fibromyalgia	Y N	Stroke	Y N
Fractures (Broken Bones)	Y N	Thyroid Problems (Hyper or Hypo)	Y N
Headaches (Chronic, Migraine)	Y N	Ulcerative Colitis (Crohns)	Y N
Heartburn (GERD)	Y N	Vitamin D Deficiency	Y N
Heart Attack	Y N	Other:	Y N

SURGERIES

☐ None

TYPE *(Specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation:
Total Number of Preganancies:	Number of Live Births:
Pregnancy Complications:	Age of Menopause:

Name : ______________________________ Chart: ____________________

OTHER HEALTH ISSUES

TOBACCO USE ☐**Smoke Free Home**
Smoke Cigarettes? Y N At what age did you start? ______ ☐ Have Never Smoked *(Skip to Alcohol/Drug Use)*
Current: Packs/day ______ # of Years ______ ***Past:*** Quit Date: ____________ Packs/day ______ # of Years______
Other Tobacco (check one): ☐Pipe ☐Cigar ☐Snuff ☐Chew ☐E. Cigarette ☐Vape ☐Hookah
ALCOHOL/DRUG USE ☐ **Never Drank Alcohol** ☐ **Have Never Used Drugs**
Do you drink alcohol? Y N ☐ Beer ☐ Wine ☐ Liquor # of Drinks/week:
Do you use marijuana or recreational drugs? Y N Have you ever used needles to inject drugs? Y N
Have you ever taken someone else's drugs? Y N
SEXUAL ACTIVITY
Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*
Sexual partner(s) is/are/have been: ☐Male ☐Female ☐Booth
Birth control method: ☐None ☐Condom ☐ Pill/Ring/Patch/Depo/IUD ☐Vasectomy
Have you ever been sexually abused? No Yes, but it is not a problem Yes, and it's still causing a significant problem
EXERCISE
Do you exercise regularly? Y N *If you answer no, please move to Sleep)*
What kind of exercise? How long (min.) ___________ How often: ___________
SLEEP
How many hours, on average, do you sleep at night *(or during the day, if working night shift)?*
DIET
How would you rate your diet: ☐Good ☐Fair ☐Poor
Would you like to schedule an appointment with the health nurse for advice on your diet? Y N
SAFETY
Have you ever witnessed family violence? Y N
Have you ever experienced violence against your own person? Y N
Do you know what domestic violence is? Y N
Have you ever been in an abusive relationship in the past? Y N
Do you feel safe in your current relationship? Y N ☐ Not in a relationship
Do you use seat belts consistently? Y N Do you use a bike helmet? Y N
Working smoke detector in home? Y N If you have guns at home, are they locked up? Y N
Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

Name : ______________________________ Chart: ____________________

FAMILY MEDICAL HISTORY

☐ No Significant Family History is Known

CHECK ALL THAT APPLY	Mother	Father	Brother	Sister	Child	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father
Alcoholism									
Arthritis									
Asthma									
Bleeding Disorder									
Cancer *(type ________________)*									
Depression/Anxiety									
Diabetes									
Early Death									
Emphysema (COPD)									
Epilepsy/Convulsions									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Mental Illness									
Migraine/Chronic Headaches									
Osteoporosis									
Stroke									
Tobacco Use									
Thyroid Disease									

SOCIAL HISTORY

Occupation *(or prior occupation)*:	☐ Retired ☐ Unemployed ☐ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? ☐ Yes ☐ No	
Marital Status *(check one)*: ☐ Single ☐ Partner ☐ Married ☐ Divorce ☐ Widowed ☐ Other:	
Do you have children? ☐ Yes ☐ No	If yes how many?

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 60 days? Y N	If yes where?
Have you served in the military: Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Name : ______________________________ Chart: ______________

OTHER PROVIDES/SPECIALISTS

Please list all providers/specialist you have seen within the last 7 years.

Provider/Specialist	Name and Address/Phone Number	Last Visit
Family Doctor		
Urgent Care		
ER/Hospital		
Allergist		
Cardiology		
Counseling/Therapy		
Ear Nose & Throat		
Gastroenterology		
Neurology		
OB/GYN		
Orthopedics		
Pulmonary		
Physical Therapy		
Psychiatry		
Urologist		
Other:		

Reason for transferring care:
Reason for initial visit:

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