Unity Care NW

CURRENT HEALTH & MEDICAL HISTORY -- ADULT: AGE 19 AND UP

Patient Name:_______________________________________ **Date of Birth**:________________ **Age**:__________

PAST OR PRESENT PHYSICAL & MENTAL ILLNESSES / SURGERY / HOSPITALIZATIONS			
	YEAR		YEAR
1.		5.	
2.		6.	
3.		7.	
4.		8.	

FAMILY HISTORY

Disease or Condition	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Brother	Sister	Son	Daughter	Other
Alcoholism											
Allergies											
Anxiety											
Asthma											
Bipolar Disorder											
Bleeding Disorder											
Cancer: Breast											
Cancer: Cervical											
Cancer: Colon											
Cancer: Lung											
Cancer: Ovarian											
Cancer: Prostate											
Cancer: Other											
Clotting Disorder											
Depression											
Diabetes											
Drug problem											
Epilepsy/Seizures											
Headaches											
Heart Problems											
High Blood Pressure											
Migraines											
Schizophrenia											
Stroke											
Thyroid problem											
Other											

CURRENT MEDICATIONS

List All Prescriptions, Herbs, Vitamins, Over the Counter Medications	Dose	Times per Day	Reason/Diagnosis for Medication

Your Pharmacy: ☐ Unity Care Bellingham ☐ Unity Care NWHC

☐ Other: ____

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ALLERGIES		
Medication / Food	**Type of Reaction**	☐ **No Known Allergies**

SUBSTANCE RISK FACTORS					
Nicotine use?	☐ Cigarettes ☐ CURRENT	☐eCigarettes ☐ QUIT	☐Cigars ☐ NEVER	☐Chew	☐Nicotine Replacement
Passive smoke exposure?	☐ YES	☐ NO			
Alcohol use?	☐ CURRENT ☐ QUIT ☐ NEVER	Type______________ Average # of Drinks ___________ per ☐ day ☐ week ☐ month Date Quit __________			
Drug use? (Example: marijuana, meth, Opiates, cocaine, bath salts)	☐ CURRENT ☐ QUIT ☐ NEVER	Date of Last Use_________________ Substances used_____________ Date Quit __________ Substances used_____________			
Ever Use IV Drugs?	☐ YES	☐ NO			

SEXUAL HISTORY
Anatomical Survey: Do you have a? (check all that apply) ☐ PENIS ☐ PROSTATE ☐ VAGINA ☐ CERVIX ☐ UTERUS ☐ BREASTS
Have you been sexually active in the last 12 months? ☐ YES ☐ NO Number of partners in the past 6 MONTHS: 12 MONTHS:
Do your current sexual partner(s) have a? (check all that apply) ☐ PENIS ☐ VAGINA ☐ OTHER ☐ NOT ACTIVE
Do your past sexual partner(s) have a? (check all that apply) ☐ PENIS ☐ VAGINA ☐ OTHER ☐ NOT ACTIVE
Have you ever been diagnosed with a STD/STI, including HPV? ☐ YES ☐ NO IF YES, indicate name of STI:
Have your sexual partners ever used illegal injection drugs? ☐ YES ☐ NO ☐ UNKNOWN
Do you use condoms to protect against STI/STD? ☐ SOME OF THE TIME ☐ ALL OF THE TIME ☐ NEVER ☐ NOT ACTIVE
Are you using birth control? ☐ YES ☐ NO IF YES, indicate method:
If you have a cervix: Have you ever had an abnormal pap? ☐ YES ☐ NO Year:
The CDC recommends a one-time HIV test for everyone age 13-64, and a one-time hepatitis C screening for all adults aged 18 years and older. Additional testing may be recommended depending on your medical history and risk factors. Talk to your provider if you want to be tested, or if you want more information about safer sex, birth control, or STDs/STIs

LIFESTYLE				
Caffeine use?	☐ YES	☐ NO	If YES, ___________ drinks per day	
Works with hazardous materials/ chemicals?	☐ YES	☐ NO		
Do you have any tattoos?	☐ YES	☐ NO		
Do you feel physically and emotionally safe where you currently live? ☐ YES ☐ NO ☐ UNSURE ☐ CHOOSE NOT TO ANSWER				
In the past year, have you been afraid of your partner or ex-partner? ☐ YES ☐ NO ☐ UNSURE ☐ I HAVE NOT HAD A PARTNER IN THE LAST YEAR ☐ CHOOSE NOT TO ANSWER				
Do you exercise regularly?	☐ YES	☐ NO		
Do you regularly use seat belts?	☐ YES	☐ NO		
Guns in the home?	☐ YES	☐ NO		
Sun Exposure?	☐ FREQUENTLY	☐ OCCASIONALLY	☐ RARELY	☐ REMOTE
Do you struggle with:	☐ Hearing ☐ Climbing Stairs	☐ Seeing ☐ Dressing or Bathing	☐ Making Decisions ☐ Running Errands	

HEALTH SCREENING		
List the Year and Location of Most Recent	**Date**	**Location**
Annual Exam / Well Child Check		
Colonoscopy		
Pap Test		
Mammogram		
Bone Density or DEXA		
Vaccines		

Signature:____Date: _______________