Nimkee Memorial Wellness Center
New Patient Health Assessment

Full Name: ________________________Nickname:______________________Age:____Date:___________
Present Occupation: ____Years:______
Previous Occupation: ____Years:______
Name and address of the Medical Provider you have been seeing:
____
____

What are your primary health concerns at this time?
____
Have you established an advanced directive?
____
Are you having pain? [ ] Yes [ ] No If so, where? ____
Date of last physical examination?____

SELF MEDICAL HISTORY:

		Comments
Diabetes	[ ] Yes [ ] No	If yes, specify type: ________________________
Hypertension	[ ] Yes [ ] No	____
High Cholesterol	[ ] Yes [ ] No	____
Heart Disease	[ ] Yes [ ] No	____
Arthritis	[ ] Yes [ ] No	____
Glaucoma	[ ] Yes [ ] No	____
TB or Lung Disease	[ ] Yes [ ] No	____
Rheumatic Fever	[ ] Yes [ ] No	____
Liver Disease	[ ] Yes [ ] No	____
Kidney Disease	[ ] Yes [ ] No	____
Seizure/Epilepsy	[ ] Yes [ ] No	____
Cancer	[ ] Yes [ ] No	____
Sexually Transmitted Disease	[ ] Yes [ ] No	____
Alcohol Abuse	[ ] Yes [ ] No	____
Drug Abuse	[ ] Yes [ ] No	____
Hearing Impaired	[ ] Yes [ ] No	____
Paralysis	[ ] Yes [ ] No	____
Vision Impaired	[ ] Yes [ ] No	____
Blood Transfusion	[ ] Yes [ ] No	____
Sinus Trouble	[ ] Yes [ ] No	____
AIDS/HIV	[ ] Yes [ ] No	____
Hepatitis	[ ] Yes [ ] No	____
Asthma	[ ] Yes [ ] No	____
Anemia	[ ] Yes [ ] No	____
Mental Disorder	[ ] Yes [ ] No	____
Food Allergies	[ ] Yes [ ] No	____
Birth Defects	[ ] Yes [ ] No	____

Blood Defects [ ] Yes [ ] No ________________________________
Obesity [ ] Yes [ ] No ________________________________
Ulcers [ ] Yes [ ] No ________________________________
Heart Murmur [ ] Yes [ ] No ________________________________
Heart Attack [ ] Yes [ ] No ________________________________
Heart Valve [ ] Yes [ ] No ________________________________
Pacemaker [ ] Yes [ ] No ________________________________
Artificial Joint [ ] Yes [ ] No ________________________________
Stroke [ ] Yes [ ] No ________________________________
Ever been hospitalized [ ] Yes [ ] No ________________________________
Surgeries [ ] Yes [ ] No ________________________________
Surgery & Date:____
Have you ever been threatened or abused (physically, sexually, or emotionally)
by your partner? [ ] Yes [ ] No ________________________________

FAMILY HISTORY:
Diabetes [ ] Yes [ ] No ________________________________
Hypertension [ ] Yes [ ] No ________________________________
High Cholesterol [ ] Yes [ ] No ________________________________
Heart Disease [ ] Yes [ ] No ________________________________
Rheumatoid Arthritis [ ] Yes [ ] No ________________________________
Glaucoma [ ] Yes [ ] No ________________________________
Tuberculosis [ ] Yes [ ] No ________________________________
Obesity [ ] Yes [ ] No ________________________________
Ulcers [ ] Yes [ ] No ________________________________
Kidney Disease [ ] Yes [ ] No ________________________________
Seizures [ ] Yes [ ] No ________________________________
Cancer [ ] Yes [ ] No ________________________________
Asthma [ ] Yes [ ] No ________________________________
Mental Disorder [ ] Yes [ ] No ________________________________
Have your children ever been abused (physically, sexually or emotionally)
by your partner? [ ] Yes [ ] No ________________________________

OVER THE LAST 2 WEEKS, HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS:

Little interest or pleasure in doing things?
[ ] Yes [ ] No ________________________________
Feeling down, depressed or hopeless?
[ ] Yes [ ] No ________________________________

HEALTH FACTORS:

Do you drink alcohol? [ ] Yes [ ] No ______________________________________
Do you drink more than 4 or 5 drinks in 1 day?
[ ] Yes [ ] No ______________________________________
Have you ever tried to cut down on your drinking?
[ ] Yes [ ] No ______________________________________
Do you get annoyed when people talk about your drinking?
[ ] Yes [ ] No ______________________________________
Do you feel guilty about your drinking?
[ ] Yes [ ] No ______________________________________
Have you ever had an "eye opener"? (A drink first thing in the morning)
[ ] Yes [ ] No ______________________________________
Do you smoke tobacco? [ ] Yes [ ] No ______________________________________
Is there a smoker in the home? [ ] Yes [ ] No ______________________________________
Do you use smokeless tobacco? [ ] Yes [ ] No ______________________________________
Are you a previous tobacco smoker? [ ] Yes [ ] No ______________________________________
Year quit: __________
Do you use contraception? [ ] Yes [ ] No ______________________________________

INFANTS AND CHILDREN ONLY:

Please select your infant feeding choice: [ ] Breastfeeding [ ] Formula
Live in or regularly visit a house built before 1950? (Including daycare, pre-school,
home of friend or relative, etc.) [ ] Yes [ ] No ______________________________________
Live in or regularly visit a home built before 1978 with recent, on-going,
or planned renovation/remodeling? [ ] Yes [ ] No ______________________________________
Do you give your child any home or folk remedies?
[ ] Yes [ ] No ______________________________________
Has a sibling, housemate, or playmate been followed or treated for lead poisoning?
[ ] Yes [ ] No ______________________________________
Live near a active lead smelter, battery recycling plant, other lead industry, or near a heavily
traveled highway? [ ] Yes [ ] No ______________________________________
Live with an adult whose job or hobby involves exposure to lead?
[ ] Yes [ ] No ______________________________________

WOMEN ONLY:

Are you currently pregnant? [ ] Yes [ ] No ______________________________________
Currently breast feeding? [ ] Yes [ ] No ______________________________________
Date of last Pap smear? ______________________________________
Date of last Mammogram? ______________________________________
Date of last Menstrual period? ______________________________________

DO YOU HAVE ANY DRUG, FOOD OR OHER ALLERGIES? (NAME, REACTION, AND DATE IF KNOWN)

PLEASE LIST ALL CURRENT MEDICATIONS: (Prescribed & Over the Counter)

IMMUNIZATION HISTORY:

OTHER SOURCES OF HEALTH CARE OUTSIDE OF THIS CLINIC:

DO YOU HAVE ANY SPECIALIZEDCOMMUNICATION NEEDS INCLUDING LANGUAGE, READING, OR WRITING? [ ] Yes [ ] No

DO YOU HAVE ANY OTHER MEDICAL CONCERNS YOU WOULD LIKE US TO KNOW ABOUT?