North Olympic Healthcare NETWORK

NEW PATIENT HEALTH ASSESSMENT

Patient Name:		**Date of Birth:**
Preferred Name:	**Preferred Gender:**	**Gender at Birth:**

Medical History: _____

_____

_____

Surgeries: _____

_____

_____

Allergies:

Medications: _____

_____

Family History:

Mother:	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Stroke
☐ Diabetes	☐ Mental Illness	☐ Colon Cancer	☐ Breast Cancer	☐ Prostate Cancer
Maternal Grandmother:	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Stroke
☐ Diabetes	☐ Mental Illness	☐ Colon Cancer	☐ Breast Cancer	☐ Prostate Cancer
Maternal Grandfather:	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Stroke
☐ Diabetes	☐ Mental Illness	☐ Colon Cancer	☐ Breast Cancer	☐ Prostate Cancer
Father:	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Stroke
☐ Diabetes	☐ Mental Illness	☐ Colon Cancer	☐ Breast Cancer	☐ Prostate Cancer
Paternal Grandmother:	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Stroke
☐ Diabetes	☐ Mental Illness	☐ Colon Cancer	☐ Breast Cancer	☐ Prostate Cancer
Paternal Grandfather:	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Stroke
☐ Diabetes	☐ Mental Illness	☐ Colon Cancer	☐ Breast Cancer	☐ Prostate Cancer
Sister:	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Stroke
☐ Diabetes	☐ Mental Illness	☐ Colon Cancer	☐ Breast Cancer	☐ Prostate Cancer
Brother:	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Stroke
☐ Diabetes	☐ Mental Illness	☐ Colon Cancer	☐ Breast Cancer	☐ Prostate Cancer

Tobacco/Alcohol/Substance Use:

Smoking:	☐ Never	☐ Former	☐ Every Day	☐ Some Days
If yes to "Former / Every Day / Some Days":		☐ Cigarettes	☐ Pipe	☐ Cigars
Passive Exposure (Secondhand Smoke):		☐ Never	☐ Past	☐ Current
Smokeless (Chewing Tobacco):		☐ Never	☐ Former	☐ Current
Vaping:	☐ Current Every Day	☐ Current Some Days	☐ Former User	☐ Never
Alcohol Use:	☐ Yes ☐ Not Currently	Drinks per day_____ ☐ Never	Drinks per week_____	
Substance Use:	☐ Yes	☐ Not Currently	☐ Never	

Physical Activity:

On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?_____

Sexual Activity:

Are you sexually active?	☐ Yes	☐ Not currently	☐ Never	
If yes:	Partner(s): ☐ Male	☐ Female	Type of birth control/protection:_____	

Social Connections:

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?
☐ Never ☐ Once a week ☐ Twice a week ☐ Three times a week ☐ More than 3x
☐ Choose not to disclose

How often do you get together with friends or relatives?
☐ Never ☐ Once a week ☐ Twice a week ☐ Three times a week ☐ More than 3x
☐ Choose not to disclose

How often do you attend church or religious services?
☐ Never ☐ Once a week ☐ Twice a week ☐ Three times a week ☐ More than 3x
☐ Choose not to disclose

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?
☐ Yes ☐ No ☐ Choose not to disclose

How often do you attend the meetings of the clubs or organizations you belong to?
☐ Never ☐ 1-4 times per year ☐ More than 4x per year ☐ Choose not to disclose

Are you married, widowed, divorced, separated, never married, or living with a partner?
☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never married
☐ Living with a partner ☐ Choose not to disclose

Do you have any Advanced Care Planning Documents? (i.e., Durable Power of Attorney for Healthcare, Advanced Directive or POLST)? ☐ Yes ☐ No If no, please ask your provider about these.

Signature: _____ **Date:** _____

*****<u>For Future Use</u>***** Please initial and date below once you have reviewed this form at <u>each annual review</u>.

_____ | _____ | _____ | _____ |
_____ | _____ | _____ | _____ |