Tri-County
Community Action Agency
Helping people. Changing lives.

Adult Patient History

We'd like to welcome you as a new patient. Please take the time to fill out this form as best you can so we can help to care for you.

We take protecting your health information very seriously in accordance with federal protections under the Health Insurance Portability and Accountability Act (HIPAA).

While this clinic recognizes a number of sexes/genders, many insurance companies and legal entities do not. Please understand that the legal name and sex listed on your insurance must be used on documents for insurance and billing. If your preferred name and pronouns are different from these, please let us know.

Name: _____ **Preferred Name**: _____ **Date of Birth**: _____

Home Address: _____ **Phone**: _____

Sex/Gender: Male/Female/Intersex/Transgendered **Preferred Pronoun**: He/She/They

Pharmacy Name and Address: _____

Who was your previous medical provider? _____

Do you have an advance directive or living will? ☐ Yes ☐ No

Do you have a healthcare proxy or medical power of attorney, allowing them to make decisions about your care in life-threatening situations? ☐ No ☐Yes (name of person and relationship to you) _____

Education Level: _____ **Occupation (Please describe your work)**: _____

Relationship Status (eg, single, married, partnered, living together, divorced): _____

Name of your partner or spouse: (if applicable) _____ **Number of children**:_____

Do you live with anyone? ☐Yes ☐No **Do you feel safe at home?** ☐Yes ☐No

Languages spoken most often at home: _____ **Do you need an interpreter?** ☐Yes ☐No

Your Health History: (Please check all that you have had)

Disease/Condition		Disease/Condition	
Seizures		Cancer	
Stroke/TIA		Diverticulitis/diverticulosis	
Memory Problems		Crohn's Disease or Colitis	
Trouble Seeing or Hearing		Liver Disease or Hepatitis A,B,C	
Blood clots in legs/lungs		Kidney Disease	
History of Heart Attack or Heart Disease		Abnormal Mammogram or Pap Smear	
High Blood Pressure		Diabetes	
High Cholesterol		Thyroid Problem	
Tobacco use		Osteoporosis/Osteopenia	
Atrial Fibrillation		Chronic Pain	
Murmur		Anxiety or Panic Disorder	
Asthma		Bipolar	
Emphysema/COPD		Depression	
Tuberculosis		Schizophrenia	
HIV		Posttraumatic Stress Disorder (PTSD)	
Sexually Transmitted Infections		Alcohol or Substance Use Problem	
Prostate Problems		Other:	

Current Medications: (Please list all medications including supplements that you are taking)

☐ **I do not take any medications**

Medication Name	Dose /Times per day	Reason For Taking	Who Prescribes?

Have you had an allergic reaction to medications, foods, latex or any other substances?

☐ **No Allergies**

Allergy	Reaction/What Happens	Allergy	Reaction/What Happens

Immunizations with dates: (If unknown, write unknown)

Vaccine	Date (s)	Vaccine	Date (s)
Pneumonia shot		Hepatitis A and B Series	
Flu shot		MMR	
Whooping Cough(Pertussis)/Tdap		Chicken Pox Vaccine	
Tetanus Shot		Meningitis	
Zoster/Shingles		HPV Shot	

Prevention: (If unknown, write unknown)

Service	Date of last	Service	Date of last
Colonoscopy		Stool Card for hidden blood	
Mammogram		Prostate Exam	
Pap Smear		DEXA Bone Scan (for osteoporosis)	
Eye Exam		HIV testing	

Specialists: (Include dentist, eye doctor, gynecologist, counselor/therapist, etc

☐ **No Specialists**

Specialty	Name	Date Last Visit	Reason For Visit

Surgical History: (Please be as specific as possible - example: left hip replacement)

☐ **No known surgeries**

Surgery	Date of Surgery/ Reason

Family Medical History: (Please list medical problems that run in the family)

☐ **I do not know my family history**

	Conditions/Diseases
Parents	
Siblings	
Other relatives	

Sexual History/Sexual Orientation:

Are you sexually active? ☐ Yes ☐ No How do you identify in terms of sexual orientation? _____ Are you sexually active with (check all that apply): ___Men ___Women ___Both ___Other
Do you have a primary (main) sexual partner? ☐ Yes ☐ No Do you have any casual sexual partners? ☐ Yes ☐ No
When you have sex, do you have (check all that apply): ___Oral Sex ___Vaginal Sex ___Anal Sex
How often do you use condoms when having: _____Oral Sex _____Vaginal Sex _____Anal Sex When is the last time you had sex without using a condom? _____
When was the last time you were tested for HIV or other sexually transmitted infections (STI)? _____
Have you ever had an STI (Syphilis, Gonorrhea, Chlamydia, Herpes, Genital Warts, Trichomonas)? ☐ Yes ☐ No Have any of your partners had or been tested for HIV or other sexually transmitted infections? ☐ Yes ☐ No ☐ Unsure
Do you have any concerns about your sexual life or health? ☐ Yes ☐ No
Would you like to become pregnant in the next year? ☐ Yes ☐ No Current birth control method: _____
Has anyone ever forced you into any type of sexual activity? ☐ Yes ☐ No

Obstetric History:

Are you pregnant? ☐ Yes ☐ No Have you ever been pregnant? ☐ Yes ☐ No Age at first birth _____
Vaginal Birth (#) ____ C-Section Birth (#) ____ Miscarriage (#) ____ Abortion (#) ____ Living Children (#) _____
History of abnormal pap smear? ☐ Yes ☐ No Age of first menstrual period _____ Age of menopause _____ Date of last menstrual period _____

Social and Health Habits:

How often do you drink alcohol? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never Is your alcohol use a concern for you or others? ☐No ☐Yes Explain: _____
Would you like to stop drinking? ☐No ☐Yes
Have you ever used any of the following (please check all that apply): ___Marijuana ___Cocaine ___Heroin ___Crystal Meth ___Ecstasy/Mushrooms/LSD ___Other opiates (Vicodin, Percocet, Oxycontin)
Do you now or have you ever had a problem with prescription drug use? ☐ Currently ☐ Never ☐ Past/Former If so, what drugs? _____
Have you *ever* injected any type of substance? ☐Yes ☐No
Do you use tobacco? ☐Yes ☐No ☐Former Type of tobacco: _____ Date quit _____ Would you like to quit smoking? ☐Yes ☐No Have you ever tried to quit smoking? ☐Yes ☐No
Do you follow a special diet? ☐Yes ☐No If so, please explain: _____

Do you have concerns about your eating habits? ☐Yes ☐No If so, please explain: _____ What types of exercise and or sports do you engage in? _____
Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone? ☐Yes, in the past year ☐Yes, prior to the past year ☐No
Do you have a particular religion or spiritual belief that you would like us to know about? ☐Yes ☐No If so, which religion or spiritual belief: _____

Thank you!

Patient Signature:_____ **Print Name:**_____**Date** _____