HUNTER HEALTH | NEW PATIENT HEALTH HISTORY FORM (ADULT)

BASIC INFORMATION

NAME	TODAY'S DATE
DATE OF BIRTH	**MARITAL STATUS** MARRIED SINGLE DIVORCED WIDOW / WIDOWER
WORK STATUS / OCCUPATION	PREFERRED PHARMACY
SEX AT BIRTH MALE FEMALE	**GENDER IDENTIFICATION** (ex. male, female, transgender, gender neutral, non-binary...)

SPECIALISTS / OTHER CARE PROVIDERS

SURGERY (including any eye/ear surgeries and hysterectomy or breast procedures)

LIST ALL SURGERIES, INCLUDE YEAR (Note left-side or right-side, when applicable)

PAST AND PRESENT MEDICAL PROBLEMS (circle and describe)

CARDIOVASCULAR

HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
PERIPHERAL ARTERY DISEASE
HISTORY OF BLOOD CLOT
HISTORY OF HEART RHYTHM DISORDER (describe)
HEART DISEASE (describe)

NO PROBLEMS

GASTROINTESTINAL

GERD
DIVERTICULOSIS
COLON POLYPS
HEMORRHOIDS
LIVER DISEASE (describe)

BOWEL DISEASE (describe)

NO PROBLEMS

GENITOURINARY

RECURRENT UTI
URINARY INCONTINENCE
PROSTATE ENLARGEMENT
KIDNEY STONES
KIDNEY DISEASE (describe)

GYNECOLOGIC DISEASE (describe)

NO PROBLEMS

EYES, EARS, NOSE, THROAT

CATARACT
GLAUCOMA
HEARING PROBLEM
SINUSITIS, ALLERGIES
DENTURES, IMPLANTS
VISION PROBLEM (describe)

NO PROBLEMS

INFECTIOUS DISEASE

HISTORY OF CHICKEN POX / SHINGLES
HISTORY OF TUBERCULOSIS
HIV
HEPATITIS **A** **B** **C**
HISTORY OF MRSA
NO PROBLEMS

PULMONARY

ASTHMA
COPD / EMPHYSEMA
SLEEP APNEA
NO PROBLEMS

RHEUMATOLOGY

ARTHRITIS
GOUT
RHEUMATOID ARTHRITIS
FIBROMYALGIA
NO PROBLEMS

ENDOCRINE

THYROID DISEASE **LOW** **HIGH**
DIABETES
OSTEOPOROSIS
NO PROBLEMS

NEUROPSYCHIATRIC

ANXIETY
DEPRESSION
BIPOLAR
SEIZURES
MEMORY PROBLEMS / DEMENTIA
MIGRAINE
NEUROPATHY
SCHIZOPHRENIA
HISTORY OF STROKE
OTHER MOOD DISORDER (describe)

NO PROBLEMS

CANCER

TYPE / LOCATION

YEAR

TREATMENT **SURGERY** **CHEMO** **RADIATION**
ONCOLOGIST
NO CANCER

OTHER PROBLEMS

PLEASE LIST

HUNTER HEALTH

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REVIEW OF SYMPTOMS (circle all symptoms that you have had in the last few days)

GENERAL

CHILLS
FATIGUE
FEVER
NIGHT SWEATS
WEIGHT GAIN / LOSS

NEUROLOGICAL

DIFFICULTY SPEAKING
FAINTING
HA
LOSS OF STRENGTH
MEMORY LOSS
SEIZURES
TINGLING / NUMBNESS
TREMOR

PSYCHOLOGICAL

ANXIETY
DEPRESSED MOOD
DIFFICULTY SLEEPING
MENTAL OR PHYSICAL ABUSE

EYE

BLURRY VISION
EYE PAIN

ENT

RUNNY NOSE
CONGESTION
DIFFICULTY SWALLOWING
EAR PAIN
RINGING IN EARS
SNORING
SORE THROAT

ENDOCRINE

COLD INTOLERANCE
EXCESSIVE THIRST
HAIR LOSS
HEAT INTOLERANCE

RESPIRATORY

COUGH
SHORTNESS OF BREATH
WHEEZING

CARDIOVASCULAR

CHEST PAIN
PAIN IN LEGS WITH WALKING
FLUID ACCUMULATION IN LEGS
DIFFICULTY BREATHING WHEN LAYING FLAT
PALPITATIONS

GASTROINTESTINAL

ABDOMINAL PAIN
BLOOD IN STOOL
CONSTIPATION
DIARRHEA
HEARTBURN
NAUSEA
VOMITING

MUSCULOSKELETAL

MUSCLE ACHES
JOINT PAIN
JOINT SWELLING

ALLERGY / IMMUNOLOGY

IMMUNE DEFICIENCY
SEASONAL ALLERGIES

HEMATOLOGY

BLEEDING PROBLEMS
EASY BRUISING

SKIN

DISCOLORATION
ITCHING
CHANGE IN MOLES OR SPOTS
RASH

URINARY

BLOOD IN URINE
DIFFICULTY URINATING
KIDNEY PROBLEMS
PAINFUL URINATION

BREAST

LUMP
PAIN
NIPPLE DISCHARGE
SKIN CHANGES

WOMEN

PELVIC PAIN
MENOPAUSAL SYMPTOMS
GENITAL SORES / RASH
IRREGULAR PERIODS
VAGINAL DISCHARGE / ITCHING

MEN

ERECTILE DYSFUNCTION
PENILE DISCHARGE
GENITAL SORES / RASH

OTHER

FAMILY HISTORY (List major health problems of blood relatives, if known. If deceased, list age at death.)

MOTHER	FATHER
SIBLINGS	CHILDREN
GRANDPARENTS	AUNT / UNCLE

○ CHECK IF YOUR FAMILY HISTORY IS UNKNOWN DUE TO ADOPTION OR OTHER CIRCUMSTANCES.

SOCIAL HISTORY (circle and provide details)

SMOKING (# packs per day)
eCIGARETTE / HOOKAH / VAPOR
SNUFF / CHEW (# cans per day)
ALCOHOL (# per week)
STREET DRUGS:
MARIJUANA / CBD / KRATOM
(please list others)

WHO DO YOU LIVE WITH?
DO YOU FOLLOW A SPECIAL DIET? **YES / NO**
DO YOU EXERCISE?
DO YOU SLEEP WELL?
DO YOU HAVE ANY: **ADVANCED DIRECTIVES / LIVING WILL / DURABLE POWER OF ATTORNEY**

NEW PATIENT HEALTH HISTORY FORM (ADULT)

SEXUAL / REPRODUCTIVE HISTORY (Please answer questions based on sex at birth.)

NUMBER OF BIOLOGICAL CHILDREN:

NUMBER OF ADOPTED CHILDREN:

ARE YOU CURRENTLY SEXUALLY ACTIVE? **YES / NO**

ARE YOUR PARTNERS: **MEN / WOMEN / BOTH**

HOW MANY SEXUAL PARTNERS HAVE YOU HAD IN THE LAST YEAR?

DO YOU USE ANY FORM OF CONTRACEPTION? **YES / NO**

IF YES, WHAT FORM?

HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE? **YES / NO**

IF YES, WHICH: HERPES / GONORRHEA / CHLAMYDIA / HIV
GENITAL WARTS / SYPHILIS / TRICHOMONAS

WOMEN

DO YOU HAVE PERIODS? **YES / NO**

FIRST DAY OF LAST PERIOD:

LENGTH OF PERIODS:

HOW OFTEN DO YOU HAVE A PERIOD?

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? **YES / NO**

IF YES, WHEN AND OUTCOME?

HOW MANY TIMES HAVE YOU BEEN PREGNANT?

NUMBER OF VAGINAL DELIVERIES:

NUMBER OF CESAREAN SECTIONS:

REASON?

NUMBER OF MISCARRIAGES:

NUMBER OF STILLBIRTHS:

NUMBER OF ABORTIONS:

NUMBER OF TUBAL / ECTOPIC PREGNANCIES:

ANY PROBLEMS WITH PREGNANCIES OR DELIVERIES?

ANY PROBLEMS WITH POSTPARTUM DEPRESSION?

MEN

HAVE YOU EVER BEEN DIAGNOSED WITH A PROSTATE ISSUE OR HAD A PROSTATE BIOPSY?

DO YOU CURRENTLY STRUGGLE WITH STARTING, STOPPING, OR MAINTAINING A URINARY STREAM?

DO YOU HAVE A HISTORY OF TESTICULAR OR TESTOSTERONE PROBLEMS?

PRIMARY PREVENTATIVE CARE SCHEDULE

VACCINATIONS	DATE	WOMEN	DATE	MEN	DATE
TETANUS		COLONOSCOPY		COLONOSCOPY	
INFLUENZA		PAP SMEAR / HPV TESTING		PROSTATE CANCER SCREENING (PSA)	
PNEUMONIA 13		MAMMOGRAM			
PNEUMONIA 23		BONE DENSITY			
SHINGLES					
HPV		WHEN WAS YOUR LAST DENTAL EXAM?			
COVID		WHEN WAS YOUR LAST EYE EXAM?			
HEPATITIS B					

MEDICATIONS

CURRENT MEDICATIONS (include dose and frequency) WRITE ON BACK IF NECESSARY.	**MEDICATION ALLERGIES**
PLEASE INCLUDE any Durable Medical Equipment such as **Oxygen, CPAP, BIPAP, etc.**	

PATIENT / GUARDIAN SIGNATURE

DATE