PINNACLE
Family Health Care

Provider: Sasipha "Kate" Pahamark (Family Nurse Practitioner)

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New Patient Well Visit (Adult)

First Name: _______________________ **Middle Name:** ____________________ **Last Name:** __________________________

Date of Birth: _____________________ **Biological Sex:** ☐ **Male** ☐ **Female**

REASON FOR VISIT TODAY: ____

____

Allergies & Reactions: ____

____

List ALL MEDICATIONS you take *(including over-the-counter (OTC) medications, herbal supplements, and vitamins)* or ☐ **NONE**

Name of Medication	Dosage	Frequency

PERSONAL MEDICAL HISTORY: *(please select all that apply)* or ☐ **NONE**

☐ ADHD
☐ Alcoholism
☐ Allergies (seasonal)
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bipolar
☐ Bladder Problems
☐ Bleeding Problems
☐ Cancer: ___________
☐ Crohn's Disease
☐ COPD/Emphysema
☐ Dementia
☐ Depression
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Diverticulitis
☐ DVT (Blood Clot)
☐ GERD (Acid Reflux)
☐ Heart disease
☐ Heart Attack
☐ Hiatal Hernia
☐ Headaches
☐ High Blood Pressure
☐ Kidney Stones
☐ Kidney Disease
☐ High Cholesterol
☐ HIV
☐ Hepatitis
☐ Irritable Bowel Syndrome
☐ Lupus
☐ Liver Disease
☐ Macular Degeneration
☐ Irregular Heart Rate
☐ Neuropathy
☐ Osteoporosis/Osteopenia
☐ Parkinson's Disease
☐ Peripheral Vascular Disease
☐ Peptic Ulcer
☐ Psoriasis
☐ Pulmonary Embolism
☐ Rheumatoid Arthritis
☐ Seizure Disorder
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disorder
☐ Ulcerative Colitis

Other medical problems not listed above:

____

____

Have you ever had any of the following? or ☐ **NONE**

TEST	DATE
☐ Abdominal ultrasound	___________
☐ Abdominal CT/CAT scan	___________
☐ Cardiac Stress Test	___________
☐ Bone Mineral Density Testing	___________
☐ Dental Exam	___________
☐ Eye Exam	___________
☐ CT/CAT scan of lungs	___________
☐ Blood glucose testing	___________
☐ TB test	___________
☐ Sleep Study	___________
☐ Prostate Specific Antigen (PSA) testing	___________
☐ Cholesterol/Lipids testing	___________
☐ BRCA gene testing	___________
☐ Stool blood test	___________
☐ Colonoscopy	___________
☐ HIV testing	___________

TEST	DATE
☐ Chlamydia	___________
☐ Sexually Transmitted Infections Screenings	___________
☐ Hepatitis B testing	___________
☐ Hepatitis C testing	___________
☐ Syphilis	___________
☐ Gonorrhea	___________
☐ Alcohol Misuse counseling	___________
☐ Depression Screening	___________
☐ Other: _______________	___________

IMMUNIZATION	DATE OF LAST DOSE
☐ Tetanus	___________
☐ Flu vaccine	___________
☐ Pneumonia vaccine	___________
☐ Shingles vaccine	___________
☐ HPV vaccine	___________
☐ Other: ____________	___________

SURGERIES or ☐ **NONE**

Type of Surgery	Approximate Date	Hospital & Surgeon Name

PREVIOUS HOSPITALIZATIONS: *(include all non-surgical hospitalizations)* or ☐ **NONE**

Reasons for Hospital Stay	Approximate Date	Hospital Name

FEMALES ONLY:

Age when menstrual cycles began: ____ Age when menstrual cycles stopped: ____ ☐ N/A

First Day of Last menstrual period: ___________ ☐ Normal ☐ Abnormal ☐ N/A

Date of Last Pap Test: ____________________ ☐ Normal ☐ Abnormal ☐ N/A

Date of Last Pap/HVP cotest: ______________ ☐ Normal ☐ Abnormal ☐ N/A

Date of Last Mammogram: ________________ **☐ Normal ☐ Abnormal ☐ N/A**

No. of Pregnancies: ____ ☐ Term: ____ ☐ Preterm: ____ ☐ Miscarriages: ____ ☐ Abortions: ____ ☐ Living Children: ____

Do you have personal history of hysterectomy? ☐ Yes: ☐ Abdominal approach ☐ Vaginal approach or **☐ No**

If Yes, why? ____

If Yes, was your cervix removed? **☐ Yes ☐ No** *Were your ovaries removed?* **☐ Yes ☐ No**

SOCIAL HISTORY: *(please select all that apply)*

Alcohol Use
☐ Yes ☐ No ☐ Former
Years drinking ____________
Drinks per week* ____________
Type ____________
Quit Date ____________
Last Drink ____________

Tobacco Use
☐ Yes ☐ No ☐ Former
Type ____________
Amount per day ____________
Years of Use ____________
Year Quit ____________
Want to quit? ☐ Yes ☐ No

Recreational Drug Use
☐ Yes ☐ No ☐ Former
Type ____________
Years of Use ____________
Year Quit ____________
Want to quit? ☐ Yes ☐ No
IV Drug Use? ☐ Yes ☐ No

Caffeine
☐ Yes ☐ No ☐ Former
Type ____________
Amount per day ____________

Exercise
☐ Yes ☐ No
Type ____________
Hours per week ____________

Diet
Diet Type ____________
Any restriction? ☐ Yes ☐ No
If yes, specify: ________________

Sexual History
Currently sexually active?
☐ Yes ☐ No

Birth control method(s)?
☐ Yes ☐ No
If Yes, specify: _______________
Lifetime sexual partner(s): _______
New partner in past 3 months?
☐ Yes ☐ No
History of sexually transmitted infections?
☐ Yes ☐ No
If Yes, specify: _______________

Personal Safety
Do you wear seatbelt?
☐ Yes ☐ No

Do you have difficulty dressing yourself?
☐ Yes ☐ No

Do you have difficulty carrying 10 lbs?
☐ Yes ☐ No

Do you have difficulty shopping?
☐ Yes ☐ No
Have you had a fall in the last year?
☐ Yes ☐ No

Mental Health
Feeling down, depressed, or hopeless?
☐ Yes ☐ No

Do you have difficulty sleeping?
☐ Yes ☐ No

Occupation
Do you work? ☐ Yes ☐ No
☐ Retired
If yes, specify occupation:
____
☐ Full-time ☐ Part-time

* One Standard Drink is found in 12 oz. of regular beer, 5 oz. of wine, 1.5 oz. of distilled spirits.

FAMILY HISTORY:

FATHER: **Living: Age** _______________ **Deceased: Age** _________________ **Cause:** __________________________

☐ Alcoholism
☐ Anemia
☐ Asthma
☐ Arthritis
☐ Bipolar Disorder
☐ Cancer: ___________
☐ COPD/Emphysema
☐ Dementia
☐ Depression
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ DVT (Blood Clot)
☐ Heart Disease
☐ High Cholesterol
☐ High Blood Pressure
☐ Kidney Disease
☐ Migraines
☐ Osteoporosis
☐ Stroke
☐ Thyroid Disorder

Other medical problems not listed above: ____

MOTHER: **Living: Age** _______________ **Deceased: Age** _________________ **Cause:** __________________________

☐ Alcoholism
☐ Anemia
☐ Asthma
☐ Arthritis
☐ Bipolar Disorder
☐ Cancer: ___________
☐ COPD/Emphysema
☐ Dementia
☐ Depression
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ DVT (Blood Clot)
☐ Heart Disease
☐ High Cholesterol
☐ High Blood Pressure
☐ Kidney Disease
☐ Migraines
☐ Osteoporosis
☐ Stroke
☐ Thyroid Disorder

Other medical problems not listed above: ____

SIBLINGS: ____

____

☐ **Unknown family history/Adopted**

GENERAL QUESTIONS:

Are there any personal problems/concerns at home, work, or school you would like to discuss? ☐ **Yes** ☐ **No**

Are there any cultural or religious concerns you have related to your care? ☐ **Yes** ☐ **No**

Are there any financial issues that directly impact your ability to manage your health? ☐ **Yes** ☐ **No**

Are there any vision problems that affect your communication? ☐ **Yes** ☐ **No**

Are there any hearing problems that affect your communication? ☐ **Yes** ☐ **No**

Are there any limitations to understanding or following instructions? ☐ **Yes** ☐ **No**

Current Living Situation *(check all that apply):* ☐ **House or apartment** ☐ **Shelter** ☐ **Homeless**

☐ **Other:** ____

Who do you live with at home? ____ or ☐ **Live alone**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Other:** ____

How many children do you have and what ages? ____ or ☐ **NONE**

Education Level: ☐ **Elementary** ☐ **High School** ☐ **Vocational** ☐ **College** ☐ **Graduate/Professional**

List other medical providers that you see or receive treatment from on a regular basis.

(Ex: Cardiologist, Mental Health Provider, Kidney Specialist, and Dentist.)

____

____

Pharmacy: ____

Are there any other concerns that you would like to discuss during your visit today?

____

____

Patient Signature: ____ **Date**: ______________________

Provider Signature: ____ **Date:** ______________________