PRISM HEALTH

PREVIOUS PROVIDER INFORMATION
Are you transferring your care from another healthcare provider? ☐Y ☐N
If so, please list the name and phone number of your previous provider. We will also ask you to fill out a Release of Information so we can obtain your medical records. Name of Provider: ____ Phone Number: ______________________________

MEDICAL HISTORY
Please check ALL that apply:

☐Alcohol Use	☐Chronic Pain	☐Heart Disease	☐Seizures
☐Asthma	☐Depression	☐Hepatitis	☐Sleep Apnea/Snoring
☐Anemia	☐Dental Issues	☐High Blood Pressure	☐Strokes/TIA
☐Arthritis	☐Diabetes	☐High Cholesterol	☐STD/STI
☐Blood Clots	☐Dialysis	☐HIV/AIDS	☐TB
☐Cancer	☐Drug Addiction	☐Insomnia	☐Tobacco Use
☐COPD	☐Headaches	☐Mental Health Issues	☐Ulcers

REVIEW OF SYSTEMS
Please check ALL that apply and have occurred within the last three months, and lasting several days:

BLOOD	☐Anemia	☐Clots	☐Fatigue	☐Bleeding Issues
CARDIOVASCULAR	☐Chest Pain	☐Feet/Leg Swelling	☐Fainting	☐Palpitations
GASTROINTESTINAL	☐Nausea/Vomiting	☐Constipation	☐Diarrhea	☐Heartburn
GLANDS/HORMONES	☐Cold Intolerance	☐Heat Intolerance	☐Menopause	☐Menstrual Issues
MENTAL HEALTH	☐Anxiety	☐Depression	☐Hallucinations	☐Suicidal Ideations
MUSCULOSKELETAL	☐Pain	☐Stiffness	☐Swelling	☐Weakness
NEUROLOGICAL	☐Weakness	☐Headaches	☐Neck/Back Pain	☐Limb Numbness
OB/GYNECOLOGICAL	☐Burning	☐Cramps	☐Pregnancy	☐Itching
RENAL	☐Kidney Stones	☐Urgency/Pain	☐Blood in Urine	☐Incontinence
RESPIRATORY	☐Cough	☐Shortness of Breath	☐Wheezing	☐ Wet cough
SKIN	☐Bruising	☐Burns	☐Itching/Rash	☐Wounds

MEDICATIONS
List all of your current medications and dosage. Include over-the-counter, vitamins, supplements, CPAP machines, allergy medications, and anything else you take:

Medication Name	Dose	Frequency

Patient Name:____ DOB: ________________

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<table>
<tr><td colspan="2">ALLERGIES
List all medication, and other allergies (food, latex, etc.) you have as well as the reaction (hives, rash, swelling, etc.):</td></tr>
<tr><td>Allergy</td><td>Reaction</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">FAMILY HISTORY
Please list any illnesses, diseases, and/or conditions that any of your immediate family members has had:</td></tr>
<tr><td>Family Member</td><td>Illness / Disease / Condition</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">SURGICAL HISTORY
List all surgeries you have had and the date of the surgery:</td></tr>
<tr><td>Surgery</td><td>Date</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">SOCIAL HISTORY</td></tr>
<tr><td>How many caffeinated beverages do you have per day?</td><td>What caffeinated beverages do you drink?
□Coffee □Tea □Soda □Energy Drinks □Other __________</td></tr>
<tr><td>Do you smoke tobacco products? □Y □N □ Used to What do you smoke? ____________________________________
How many packs per day? ____________________________
Start date:_______________Quit date: _______________</td><td>Do you chew tobacco? □Y □N
Start date:_______________Quit date: _______________
Would you like to discuss quitting tobacco products?
□Y □N</td></tr>
<tr><td>Do you drink alcohol? □Y □N
What do you drink? □ Beer □ Wine □ Liquor</td><td>How many drinks per week? ___________________</td></tr>
<tr><td>Have you used injection drugs? □Y □N</td><td>Have you shared injection equipment? □Y □N</td></tr>
<tr><td>Do you feel unsafe in your current home? □Y □N</td><td>Have you been a victim of physical or sexual assault?
□Y □N</td></tr>
</table>

Patient Name:____ DOB: _________________

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SOCIAL HISTORY CONTINUED	
Over the last two weeks, how often have the following issues applied to you?	
Little interest or pleasure in doing things	☐Not at all ☐Several days ☐Almost every day ☐Every day
Feeling down, hopeless, depressed	☐Not at all ☐Several days ☐Almost every day ☐Every day
Trouble falling/staying asleep, sleeping too much	☐Not at all ☐Several days ☐Almost every day ☐Every day
Feeling tired or having little energy	☐Not at all ☐Several days ☐Almost every day ☐Every day
Poor appetite or overeating	☐Not at all ☐Several days ☐Almost every day ☐Every day
Feeling badly about yourself	☐Not at all ☐Several days ☐Almost every day ☐Every day
Trouble concentrating at work or school	☐Not at all ☐Several days ☐Almost every day ☐Every day
Moving/speaking slowly, or being fidgety/restless	☐Not at all ☐Several days ☐Almost every day ☐Every day
Thoughts of suicide, or hurting yourself	☐Not at all ☐Several days ☐Almost every day ☐Every day
If you checked off any of the above problems, how difficult have these problems made it for to do your work, take care of your home, or get along with other people?	☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult
SEXUAL HEALTH	
Are you currently sexually active? ☐Y ☐N	If no, have you been sexually active in the past? ☐Y ☐N
Are your sex partners (check all that apply): ☐A person with a penis ☐A person with a vagina	What body parts do you use when you have sex? ☐Penis ☐ Vagina ☐Anus ☐Mouth
Has there been any change to your sexual desire? ☐Y ☐N	If yes, please describe the change:
Have you had vaginal or anal sex with someone living with HIV? ☐Y ☐N ☐Not sure	Have you had vaginal or anal sex with someone that uses injection drugs? ☐Y ☐N ☐Not sure
What method(s) of birth control do you use? ☐Condom ☐Spermicide ☐Dental Dam ☐ IUD ☐NuvaRing ☐Depo ☐Patch ☐Withdrawal ☐None ☐Another ______________________________	On a scale of 1 – 5, with 1 being never and 5 being always, how often do you use condoms? ☐ 1 – Never ☐ 2 – Rarely ☐ 3 – Half of the time ☐ 4 – Almost always ☐ 5 – Always
Please answer this question *only* if you identify as female: Have you had vaginal or anal sex with someone that has a penis and that person also has sex with people that have a penis? ☐Y ☐N	Have you ever exchanged sex for something you need? ☐ Yes ☐ No
Have you ever had an STD/STI? ☐Y ☐N	If yes, please check all that apply: ☐Gonorrhea ☐Chlamydia ☐Herpes ☐Syphilis ☐HPV ☐HIV ☐Another ____________________________________
Have you ever been tested for HIV? ☐Y ☐N	Would you like to be tested for HIV? ☐Y ☐N
Are you trying to become pregnant? ☐Y ☐N ☐N/A	Do you have pain during intercourse? ☐Y ☐N ☐Sometimes
Do you have any questions or concerns about your sexual health? ☐ Yes ☐No If yea, please explain:	

Patient Name:____ DOB: _________________

Brief Health Screen

We ask all of our adult patients about substance use and mood because these factors can affect your health. Please ask your provider if you have any questions. Your answers on this form will remain confidential.

Alcohol

One drink = 12 oz. beer / 5 oz. wine / 1.5 oz. liquor (one shot)

1. If you were assigned male at birth: How many times in the past year have you had 5 or more drinks in a day?
   □ None □ 1 or more
2. If you were assigned female at birth: How many times in the past year have you had 4 or more drinks in a day?
   □ None □ 1 or more

Drugs

Recreational drugs include methamphetamines (speed, crystal, etc.), marijuana, inhalants (glue, aerosol, etc.), tranquilizers (Valium, Xanax, etc.), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms, etc.), or narcotic (heroin, Oxycodone, etc.).

1. How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?
   □ None □ 1 or more

Mood

1. During the past two weeks, have you been bothered by little interest or pleasure in doing things?
   □ None □ 1 or more
2. During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?
   □ None □ 1 or more

Patient Name:____________________________________ DOB: ________________

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OTHER Is there anything else you would like your medical provider to know about you?

Please read this following carefully and sign below:

I certify that the information I have given on my patient intake form is correct and complete to the best of my knowledge. I acknowledge that keeping any health information from my provider may hinder them from being able to give me adequate patient care. It is my responsibility to keep my provider informed of any new health issues that may arise.

____ ____________________

Patient Signature Date