NOAH
Neighborhood Outreach Access to Health

Health History

Patient Information

Name (Last, First, Middle)	
Preferred First Name	Birthdate

Allergies

Please List Allergies:

Medication

Medication	Strength	How Often?	When Did You Start Taking Med?

Medical History

Allergies	☐	Depression	☐	HIV/AIDS	☐
Anemia	☐	Diabetes	☐	Kidney disease	☐
Anxiety	☐	Enlarged Prostate	☐	Migraines	☐
Arthritis	☐	Erectile Dysfunction	☐	Stomach Ulcers	☐
Asthma	☐	GERD/Reflux	☐	Seizures	☐
Bipolar disorder	☐	Glaucoma	☐	Sleep Apnea	☐
Blood clot	☐	Heart Attack	☐	Stroke	☐
Blood transfusion	☐	Heart Disease	☐	Thyroid Disease/Hypothyroidism	☐
Cancer	☐	Heart murmur	☐	Valley fever	☐
Cataracts	☐	Hepatitis/Liver Disease	☐		
Congestive Heart Failure	☐	High Blood Pressure	☐		
COPD or Emphysema	☐	High Cholesterol	☐		

Other Medical History

Surgical History

Surgery	Date Performed

Circle Here If No Past Surgical History

Family History		
Relationship	**Status**	**Please List Family Member's Medical Conditions**
Mother	Living / Deceased	
Father	Living / Deceased	
Siblings (Brothers/Sisters)	Living / Deceased	
Children	Living / Deceased	
Other:	Living / Deceased	
Adopted Family History Unknown		

Social History: Please circle answer

1. Do you drink alcohol? YES / NO
   If yes, what type of alcohol and often do you drink?

2. Do you use recreational drugs? YES / NO / Former
   If yes, what type of drug use?

3. Do you exercise? YES / NO
   If yes, what type of exercise and how often?

4. Do you smoke? YES / NO / FORMER
   If yes, how long have you smoked?
   If yes, how many packs a day do you smoke?
   If former, how long did you smoke?
   If former, when did you quit?

5. Are you currently sexually active? YES / NO
   If yes, what do you use for birth control?

6. Do you use smokeless tobacco? YES / NO / FORMER

7. Do you have a living will/advanced directive? YES / NO

8. Do you have a medical power of attorny? YES / NO

9. Have you had the following exams or immunizations?

Immunization/Exam	***Date***	***Immunization/Exam***	***Date***
Influenza (flu) vaccine		If female, Mammogram	
Pnuemonia vaccine		If female, Pap Smear	
Tetanus vaccine		Bone Density Scan (DEXA)	
Shingles Vaccine		Colonoscopy	
Dental Exam		Eye Exam	

10. Please list any other