SNAHC
Sacramento Native American Health Center
a californiahealth center

MEDICAL CENTER

_____
Patient Name (Last, First, MI)

_____
Date of Birth

_____
HRN

Gender Identity ☐ **M** ☐ **Transgender M**
☐ **F** ☐ **Transgender F**

Adult Health History (ages 18 and up)

Note: This information is confidential and will be reviewed by the provider. The information will be used to update your medical record.

GENERAL HEALTH

Yes No

☐ ☐ Is your general health good? If NO, explain. _____

☐ ☐ Has there been a change in your health within the last year? If YES, explain.

_____

☐ ☐ Have you gone to the hospital or emergency room or had a serious illness in the last three years? If YES, explain. _____

☐ ☐ Do you have an Advanced Directive?

Preferred Pharmacy _____

How did you hear about us? ☐ Friend or family ☐Health Plan ☐ Social Media ☐ Other_____

MEDICATIONS - Please list all medications you take and their dosages, either prescription or over the counter.

☐ **None**

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you are transgender, are you currently on hormone therapy? ☐ Y ☐ N If yes, what is your regimen?

_____

ALLERGIES – Are you allergic to or have you had a reaction to any of the following? Check each that apply.

☐ Food (such as shellfish, nuts, etc.) If yes, what? _____
☐ Medications (such as antibiotics or pain medicine) If yes, which? _____
☐ Latex
☐ Animals
☐ Local anesthetic
☐ Other allergies you need to tell us about? If so, what? _____

ILLNESS/INJURY – Have you had any of the following conditions or illnesses? Check all that apply.

Yes	No		Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Abnormal pap	☐	☐	Migraines/Headaches
☐	☐	High blood pressure	☐	☐	Kidney Stones	☐	☐	Bipolar
☐	☐	Heart Attack	☐	☐	Abdominal bleeding or pain	☐	☐	Schizophrenia
☐	☐	Chest pain/tightness	☐	☐	Indigestion, GERD, or digestive tract inflammation	☐	☐	Borderline Personality
☐	☐	History of Heart Murmur				☐	☐	ADHD/ADD
☐	☐	Stroke	☐	☐	Peptic Ulcers	☐	☐	Post Traumatic Stress Syndrome
☐	☐	Cancer	☐	☐	Thyroid problem			
☐	☐	Hepatitis	☐	☐	Lung problems/asthma	☐	☐	Depression
☐	☐	Gallstones	☐	☐	Shortness of breath	☐	☐	Suicidal Thoughts
			☐	☐	Accidents/broken bones			

SURGERIES – Please list all surgeries or hospitalizations you have had.

SURGERY:	Date and Location of Surgery:	Complications:
HOSPITALIZATION:	**Date & Location of Hospitalization(s)**	**Reason for Admission(s):**

FAMILY HISTORY – Have any of your family members had any of the following conditions? Check all that apply.

Yes	No		Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Cancer	☐	☐	Hepatitis/liver problem
☐	☐	High blood pressure	☐	☐	Mental/emotional problem	☐	☐	Inherited disorders
☐	☐	Heart Disease	☐	☐	Alcohol/drug problem	☐	☐	Gastrointestinal problem
☐	☐	Congenital heart defects	☐	☐	Thalassemia or Sickle cell	☐	☐	Kidney or urine problem
☐	☐	Stroke	☐	☐	TB or lung problems	☐	☐	Other _____

WOMENS HEALTH - Please answer the questions that are relevant to you.

Age of first menstrual period _____
Start date of last period _____
How many days do periods last? _____
How many pregnancies? _____
Are you currently breast feeding? ☐ Y ☐ N

Are you taking hormones? ☐ Y ☐ N
Last Pap _____
Last Mammogram_____
Any women's health problems?_____

REPRODUCTIVE HEALTH

Are you interested in discussing birth control with your provider? ☐ Y ☐ N

Birth control method you use now OR have used in the past (check all that apply):

☐ None	☐ Condom	☐ Abstinence	☐ Rhythm method	☐ Withdrawal
☐ Pill	☐ Patch	☐ Vasectomy	☐ DMPA (Depo)	☐ Tubal Ligation
☐ Norplant	☐ Diaphragm	☐ Foam vaginal insert	☐ IUD or IUS	☐ Other

SOCIAL HISTORY

Yes	No	
☐	☐	Do you exercise regularly?
☐	☐	Do you feel you eat healthy foods?
☐	☐	Are your immunizations up to date?
☐	☐	Do you smoke, vape, or use tobacco?

Yes	No	
☐	☐	Do you have more than 1 or 2 alcohol drinks/day?
☐	☐	Any history of substance abuse issues?
☐	☐	In the past year, has anyone hurt you?
☐	☐	Are you at risk for HIV?

Do you need assistance for the following daily activities?

☐ Cooking	☐ Dressing	☐ Taking medications
☐ Grocery shopping	☐ Using the toilet	☐ Taking medications by injection
☐ Getting in/out of bed	☐ Getting up from a chair	

PREVENTION – When was the last time you received these immunizations and screens.

Last Tetanus Vaccine_____
Last Pneumo Vaccine _____
Last TB Test _____
Last Colonoscopy _____

The above information is true and accurate to the best of my recollection.

PLEASE REMEMBER THAT AT THIS TIME SNAHC IS NOT TAKING CHRONIC PAIN PATIENTS (i.e. "No refills for Narcotic Pain Medications such as Norco, Vicodin, Oxycontin, etc)

Patient Signature: _____ Date: _____

Provider Name: _____Signature: _____ Review Date:_____

Name _____ DOB _____ HRN _____