Health History Form

Please see below information about your appointments. Call 646-NYC-CARE (646-692-2273) if you have any questions. Complete the health history section of this form as much as you can. Bring this document to the first appointment with your new primary care provider. It will help them get to know your medical history and your health goals. We look forward to meeting you soon!

Medical Appointment

Date: _____ Time: _____

Primary Care Provider: _____ Health Center: _____

Financial Counseling Appointment

Date: _____ Time: _____

For your financial counseling appointment please bring the following, if you have them. Bring whatever you have available. We will do our best to connect you to affordable healthcare:

- Proof of identification (for example: passport, identification card, birth certificate)
- Proof of address (for example: postmarked mail, any mail with your name on it, lease)
- Proof of income (for example: W-2, pay stub, letter from employer)

Your Health History

1. How would you describe **your health**?

☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

For your first visit:
What are the top three questions you would like to discuss with your primary care provider? (Think of your health goals and concerns.) 1. 2. 3.

When you come for your visit, please bring the following:

☐ ALL of your prescription and over-the-counter medicine (such as pills, injections, inhalers, herbs, supplements, etc.)

☐ Medical records (especially vaccination record, colonoscopy or mammogram reports, and Pap smear results, etc.)

☐ Advanced directive or health care proxy form

☐ This form!

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2. When was the last time you saw a healthcare provider? _____
Where? _____ Why?_____

3. If you **smoke cigarettes**: are you interested in quitting? ☐Yes ☐No ☐ I do not smoke

4. Are you taking any **prescription medicine**?

☐ No, I do not take any prescription medicine.

☐ Yes, **and** I am bringing my all medications or a list of them.

5. Have you ever been a **patient at a hospital overnight**, or ever had a **surgery**?

☐No, I have never been a patient at a hospital overnight nor had surgery.

☐Yes. (Please explain *each* reason and when.)

Reason why you were a patient at a hospital overnight/Kind of surgery	**Date**
Example: *Heart Attack*	*May 2013*

6. Have you ever been **pregnant**? ☐ Yes ☐No ☐Not applicable
How many times?_____ How many children have you given birth to?_____

7. Would you like to become **pregnant** in the next year? ☐ Yes ☐No ☐ Unsure ☐Not applicable

8. Have you had a **Pap smear** (a test to check your cervix)? ☐ Yes ☐No ☐Not applicable
Date (*mm/yyyy*): _____ What was the result?_____

9. Have you had a **mammogram** (an X-ray of your breasts)? ☐ Yes ☐No ☐Not applicable
Date (*mm/yyyy*): _____ What was the result?_____