NEXUS
Family & Maternity Care

PATIENT INFORMATION			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	Zip:
Phone Number:	Date of Birth:	Gender:	Social Security Number:
E-Mail:	Marital Status: ☐Single ☐Partner ☐Married ☐Divorced ☐Widowed		
Race: ☐African American ☐Asian ☐Caucasian ☐Native American ☐Other		Ethnicity: ☐Non-Hispanic/Latino ☐Hispanic/Latino	
Emplyment Status: ☐Full Time ☐Part Time ☐Retired ☐Unemployed		Employer:	

GUARANTOR INFORMATION (FOR MINORS ONLY)			
Guarantor's Name:		Date of Birth:	Relationship:
Social Security Number:	Phone Number:	Employer:	
Emergency Contact #1: Relationship: Phone Number:		Emergency Contact #2: Relationship: Phone Number:	

INSURANCE INFORMATION			
Primary Insurance Company:	ID #:	Group #:	Phone Number:
Address:	City:	State:	Zip:
Policy Holder's Name (If Different):	Date of Birth:	Gender:	Relationship:
Social Security Number:	Phone Number:	Employer:	

Secondary Insurance Company:	ID #:	Group #:	Phone Number:
Address:	City:	State:	Zip:
Policy Holder's Name (If Different):	Date of Birth:	Gender:	Relationship:
Social Security Number:	Phone Number:	Employer:	

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Name: _____ Date of Birth: _____

Date: _____

ALLERGIES ☐ No Allergies

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS (Incl. Over-The Counter)	DOSE (mg, etc.)	TIMES PER DAY

PREVENTIVE CARE HISTORY

ITEM	DATE	RESULT
BONE DENSITY (DEXA) SCAN		
COLONOSCOPY		
MAMMOGRAM		
FLU VACCINE		
TDaP/TETANUS BOOSTER		
PNEUMONIA VACCINE (circle) Pneumovax Prevnar		
SHINGLES VACCINE		

WOMEN'S HEALTH HISTORY

Age of First Menstruation:	Age of Menopause:	
Total # of Pregnancies:	# Term Births:	# Preterm Births:
# of Abortions (Elective or Medical)/Miscarriages:	# of Living Children:	
# of Cesarean Sections:		
Pregnancy Complications:		
Birth Control Method: ☐None ☐Condoms ☐Pills/Patch ☐Depo ☐IUD ☐Nexplanon		

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Anxiety			
Asthma			
Bipolar Disorder			
Cancer (type: _____)			
Depression			
Diabetes (type: _____)			
COPD (emphysema/chronic bronchitis)			
Heart Attack			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol			
Hyperthyroidism			
Hypothyroidism			
Kidney Disease (stage: _____)			
Migraines			
Stroke			
Other:			
Other:			

SURGERIES

TYPE (specify left/right)	DATE	LOCATION

FAMILY MEDICAL HISTORY ☐ No Known Family History

✓ ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer	COPD	Depression/Anxiety	Diabetes	Heart Attack	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Stroke	Other:	Other:
Mother														
Father														
Brother														
Sister														
Child														
MGM														
MGF														
PGM														
PGF														
Other: _____														

TOBACCO USE	Do you smoke cigarettes? ☐Yes ☐No ☐Quit	
Current: Packs/day_____	# of Years _____	
Past: Packs/day_____	Quit Date _____	
Other Tobacco Use: ☐Vape ☐Cigar ☐Pipe ☐Snuff ☐Chew		
ALCOHOL USE		
How often do you drink alcohol? ☐Never ☐0-1x/mo. ☐2-4x/mo. ☐2-3x/week ☐4+ times/week		
How many drinks do you have when you are drinking? ☐1-2 ☐3-4 ☐5-6 ☐7-9 ☐10+		
How often do you have 5+ drinks on one occasion? ☐Never ☐Less than monthly ☐Monthly ☐Weekly ☐Daily or almost daily		
How often have you found that you were not able to stop drinking once started? ☐Never ☐Less than monthly ☐Monthly ☐Weekly ☐Daily or almost daily		
How often have you failed to do what was expected of you because of drinking? ☐Never ☐Less than monthly ☐Monthly ☐Weekly ☐Daily or almost daily		
How often have you needed a drink first thing in the morning to get going after drinking a lot? ☐Never ☐Less than monthly ☐Monthly ☐Weekly ☐Daily or almost daily		
How often have you had a feeling of guilt or remorse after drinking? ☐Never ☐Less than monthly ☐Monthly ☐Weekly ☐Daily or almost daily		
How often have you been unable to remember what happened the night before due to drinking? ☐Never ☐Less than monthly ☐Monthly ☐Weekly ☐Daily or almost daily		
Have you or someone else been injured as a result of your drinking? ☐No ☐Yes, but not in the last year ☐Yes, during the last year		
Has anyone been concerned about your drinking or suggested you cut down? ☐No ☐Yes, but not in the last year ☐Yes, during the last year		
DRUG USE	Do you use marijuana? ☐Yes ☐No	
Do you use any other recreational drugs? ☐Yes ☐No		
If yes, which one(s)? ☐Crack/cocaine ☐Heroin ☐Methamphetamine ☐Other_____		
EXERCISE	Do you exercise regularly? ☐Yes ☐No	
What kind of exercise?	How long (minutes): _____	How often: _____
SLEEP	On average, how many hours do you sleep at night (day if work at night)? _____	
DIET	My diet is… ☐Good ☐Fair ☐Poor	Would you like dietary advice? ☐Yes ☐No
Do you have a special diet or dietary restrictions? ☐Yes ☐No If yes, please list_____		
SAFETY	Do you have a working smoke detector in your home? ☐Yes ☐No	
If yes, does it detect carbon monoxide? ☐Yes ☐No		
If no, would you like help getting one? ☐Yes ☐No		
Do you have any guns in the home? ☐Yes ☐No	If yes, where is it kept? _____	
WILL/ADVANCED DIRECTIVE		
Do you have a will, health care power of attorney, or physician orders for life-sustaining treatment? ☐Yes ☐No	If no, would you like help completing them? ☐Yes ☐No	

During the past two (2) weeks, how often have you been bothered by the following?	Not at All	Several Days	More Than Half the Days	Nearly Every Day
Feeling nervous, anxious, or on edge				
Not able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Restless and find it hard to sit still				
Becoming easily annoyed or irritable				
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

	Not Hard at All	Not Very Hard	Somewhat Hard	Hard	Very Hard
How hard is it for you to pay for the very basics like food, housing, medical care, and heat?					

During the last 12 months (1 year)…	Yes	No
Has lack of transportation kept you from medical appointments or from getting medications?		
Has lack of transportation kept you from meetings, work, or from getting things needed for daily living?		
Was there a time when you were not able to pay the mortgage or rent on time?		
Was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?		
Was there a time when you worried that your food would run out before you got the money to buy more?		
Was there a time the food you bought just didn't last and you didn't have money to get more?		
Have you been afraid of your partner or ex-partner?		
Have you been humiliated or emotionally abused in other ways by your partner or ex-partner?		
Have you been kicked, hit, slapped, or physically hurt in other ways by your partner or ex-partner?		
Have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?		