



New Generation, Inc.
Care, help & hope since 1987

568 Portsmouth Avenue/P O Box 676 *Greenland, NH 03840*Phone/Fax 603.436.4989

GENERAL HEALTH INFORMATION

Name: _____

Date of Birth: _____ Due Date: _____

Are you on a special diet? Yes No If so, Explain: _____

Are you taking any medication? Yes No If so, list: _____

Are you allergic to any drugs? Yes No If so, list: _____

Are you allergic to any foods? Yes No If so, list: _____

Do you have any other allergies? Yes No If so, list: _____

Explain symptoms of allergies and reactions: _____

What precautions and treatments do you use for your allergies: _____

Have you ever:

Been hospitalized? Yes No If yes, Explain: _____

Had any surgery? Yes No If yes, Explain: _____

Had electrocardiograms, or x-rays for diagnosis or treatment? Yes No If yes, Explain: _____



New Generation, Inc.
Care, help & hope since 1987

568 Portsmouth Avenue/P O Box 676 *Greenland, NH 03840*Phone/Fax 603.436.4989

Worn glasses or contacts? Yes No

Had any dental problems? Yes No If yes, Explain: _____

When was your last dental exam? _____

Have you ever had any of the following? Please circle if yes.

- eye infections liver disease depression thyroid disease measles
- diverticulitis hernia hives or rashes hemorrhoids German measles
- bronchitis pneumonia scarlet fever rheumatic fever mumps
- polio mental illness mononucleosis STD's chicken pox
- childhood hyperactivity

Please write below any additional medical information we should know: _____

Did you have any complications that resulted from childhood diseases? _____

Do you smoke cigarettes? Yes No

Have you consumed alcohol or used drugs since your pregnancy? Yes No

Before your pregnancy? Yes No

If so, What? _____

How often? _____ How much? _____

Test and Immunizations: Please check those you have had and the year you were last given the test or immunization.

Year in box:

Chest x-ray

Tetanus shots

Smallpox shots

GI series

Polio series

HIB shots

Electrocardiogram

Flu injections

TB test

MMR shots



Care, help & hope since 1987

568 Portsmouth Avenue/P O Box 676 *Greenland, NH 03840*Phone/Fax 603.436.4989

Have you had any previous pregnancies? _____

Live Births Miscarriages Abortions Other _____

Do you now have or have you ever had

HPV/Genital Warts Yes No If yes, when _____ Treatment _____

Yeast Infection Yes No If yes, when _____ Treatment _____

Chlamydia Yes No If yes, when _____ Treatment _____

Herpes Yes No If yes, when _____ Treatment _____

Known HIV contact Yes No If yes, when _____ Treatment _____

STD;s (Syphilis, cancroids) Yes No If yes, when _____ Treatment _____

Gonorrhea Yes No If yes, when _____ Treatment _____

Exposure to tuberculosis Yes No If yes, when _____ Treatment _____

Hepatitis A Yes No If yes, when _____ Treatment _____

Hepatitis B Yes No If yes, when _____ Treatment _____

Hepatitis C Yes No If yes, when _____ Treatment _____



New Generation, Inc.

Care, help & hope since 1987

568 Portsmouth Avenue/P O Box 676 *Greenland, NH 03840*Phone/Fax 603.436.4989

It is highly recommended by the State Health Commissioner that all those living in a "public" facility have the Hepatitis B vaccination series. If you have not had this series please speak with your health care provider and proceed as directed.

Have you ever engaged in any "High Risk" behavior? Yes No If yes, when_____

Have you ever used intravenous drugs or shared needles or has a partner of yours practiced this behavior? Yes No If yes, when_____

Resident_____ Date_____