Family Medicine *of* Lincoln
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ADULT HEALTH HISTORY FORM

Patient Name: ______________________ Sex: Male Female DOB: ______________

Marital Status: ______________________ Occupation: ______________________

MY LAST EXAM WAS	
	DATE
Date of last Mammogram	
Date of last Pap Smear	
Date of last Menstrual Period	

HOSPITALIZATIONS / SURGERIES / DIAGNOSTIC TEST			
Hospitalization / Surgery / Diagnostic Test	Date	Hospitalization / Surgery / Diagnostic Test	Date

IMMUNIZATION	
Are you currently updated on all immunizations? Please circle one YES NO UNSURE	
	DATE: IF YOU REMEMBER
Last Influenza	
Last Pneumonia	
Last TB Skin Test	
Last Tetanus	

ALLERGIES OR REACTIONS ❑ None		
Substance	Year of Reaction	What Happened

LIST ANY PRESCRIPTION, HERBAL OR OVER THE COUNTER MEDICATIONS YOU ARE ON WITH DOSES YOU ARE USING		
Drug	How Often	What For ?

SOCIAL HISTORY

Tobacco ❑ Yes ❑ No Packs or Cans Per Day ________ For How Long___________ Date Quit___________________

Alcoholic Beverages Amount_____ Frequency_____ Cups of Coffee per Day__________ Pop or Tea per Day________

Have you used street drugs? ❑ Yes ❑ No Have you used IV drugs? ❑ Yes ❑ No

Total # of children in home __________ | # of Abortions______ # Miscarriages ________ # of premature births________

# of living children:__________________ # of Full Term babies: ________

How many vaginal births have you had: ________ How many cesarean births have you had: ________

Any complications of Pregnancy:

Are you afraid of anyone at home: ❑ Yes ❑ No

MENSTRUAL HISTORY

Age periods began:	Duration: # of days bleeding:	Age periods stopped:
Spacing of periods:	Amount of flow: Light Moderate Heavy	

SEXUAL HISTORY ❑ Abstinence

My sexual preference is	Male	Female	Prior Venereal Disease?	YES	NO
My current partner is:	Male	Female	Multiple Sexual Partners	YES	NO

FAMILY HISTORY

Has any Blood Relative ever had the following:	Yes	No	Relationship	Age at Onset
Cancer				
Glaucoma				
Tuberculosis				
Diabetes				
Heart Trouble				
High Blood Pressure				
Stroke				
Epilepsy				
Emotional/Mental Problems				
Suicide				
Birth Defects				
Other				
Other				

	IF CURRENTLY LIVING		IF CURRENTLY DECEASED	
	Age	Current Health Status	Age at Death	Cause of Death
Father				
Mother				
Siblings				
Children				

We believe that your family and emotional health is an important part of your physical health. Please answer these questions honestly so your doctor can provide the best possible medical care for you and your family.

1. Please check if you have recently experienced any of the following (✓):

- ❑ Feeling sad or irritable most of the time
- ❑ Sleep too much or too little
- ❑ Feel tired a lot
- ❑ Sexual problems
- ❑ Eat too much or too little, gained or lost weight
- ❑ Feel hopeless, helpless, worthless
- ❑ Thought about or attempted hurting yourself
- ❑ Anxiety or panic attacks
- ❑ Difficulty relaxing
- ❑ Feel worried
- ❑ Nightmares or flashbacks
- ❑ Memory problems, confusion
- ❑ Mood swings
- ❑ Fears, phobias
- ❑ Headaches (tension or migraines)
- ❑ So irritable or frustrated you start fights
- ❑ So excited you didn't sleep
- ❑ Eating Disorder (dieting, binging, vomiting)
- ❑ Chronic pain, low back pain, pelvic, or stomach pain
- ❑ High blood pressure, asthma, diabetes
- ❑ Believe you have serious illness or many illnesses
- ❑ Injury causing unconsciousness
- ❑ Seems like people are talking about you
- ❑ Seems like people want to hurt you
- ❑ Seeing or hearing things
- ❑ Difficulty with thinking clearly, concentrating or making decisions
- ❑ Feeling especially important or having special powers
- ❑ Marriage/relationship conflicts
- ❑ Family conflicts
- ❑ Physically, mentally or sexually abused
- ❑ Someone in family has emotional problems
- ❑ Child behavior problems
- ❑ Aging parents or family members
- ❑ Grieving
- ❑ Cultural/social adjustment
- ❑ Recent move
- ❑ Financial stress
- ❑ Facing criminal charges or legal procedure
- ❑ Job or employer-related stress
- ❑ Concerns with alcohol use
- ❑ Drug Use
- ❑ Tobacco Use
- ❑ Other ______________________________

2. How would you describe relationships in your family?
❑ Bad ❑ Poor ❑ Fair ❑ Good ❑ Excellent
Do you have caring friends? ❑ Yes ❑ No

3. How much pressure or stress is there in your life? None 1 2 3 4 5 A lot
How many changes were there in your life in the past year? None 1 2 3 4 5 A lot
How able are you to handle the stress in your life: Well 1 2 3 4 5 Not Well
Do you think that stress is affecting your health? ❑ Yes ❑ No If yes, how? ______________________________

4. In the last three months:

Have you felt you should cut down or stop drinking:	❑ No	❑ Sometimes	❑ Quite often	❑ Very Often
Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking?	❑ No	❑ Sometimes	❑ Quite often	❑ Very Often
Have you felt guilty or bad about how much you drink?	❑ No	❑ Sometimes	❑ Quite often	❑ Very Often
Have you been waking up wanting to have an alcoholic drink?	❑ No	❑ Sometimes	❑ Quite often	❑ Very Often
If you take pain or nerve pills, how often do you run short?	❑ Never	❑ Sometimes	❑ Quite often	❑ Very Often

Have any family members had problems with drugs or alcohol? ❑ Yes ❑ No
Have you ever been treated for problems with drugs and/or alcohol? ❑ Yes ❑ No

5. What do you find most satisfying about your life or yourself?

6. What do you find most worrisome about your life or yourself right now?

7. Have you ever thought about or attempted to hurt yourself? ❑ Yes ❑ No

8. Are you currently in counseling? ❑ Yes ❑ No Have you had counseling in the past? ❑ Yes ❑ No
Are you interested in getting counseling for any current problems or growing concerns? ❑ Yes ❑ No

9. Do you ever feel afraid of or threatened by your spouse, partner, or someone else who is important or close to you? ❑ Yes ❑ No

10. Within the last year, have you been hit, slapped, choked, kicked, forced to have sex or otherwise hurt by someone? ❑ Yes ❑ No If yes, who hurt you? ______________________________

REVIEW OF SYSTEMS: (Y) yes (N) no (O) occasionally											
CONSTITUTIONAL	**Y**	**N**	**O**	***CARDIOVASCULAR***	**Y**	**N**	**O**	***MEN ONLY***	**Y**	**N**	**O**
Fatigue				High blood pressure				Difficulty with erection			
Fever				Rheumatic fever				Dribbling of urine			
Chills				Chest tightness, pressure or pain				Decreased urine stream size			
Sweats				Swelling in your legs or feet				Difficulty starting urination			
Night Sweats				Sleep on more than one pillow				Prostate problems			
Weight Change				Awaken at night unable to get your breath				Discharge from the penis			
Diabetes or high blood sugar				Pounding heart beats (Palpitations)				Lump in testicles			
Anemia				Rapid heart rates for no reason				***WOMEN ONLY***	**Y**	**N**	**O**
EYES				Light headedness				History of breast lumps or Breast tissue changes			
Glaucoma				History of heart murmur				Nipple discharge			
Cataracts				Leg cramps when walking				Change in periods			
Corrective eyeglasses or lenses				Heart attack				Hot flashes			
Recent visual change				***GASTROINTESTINAL***	**Y**	**N**	**O**	Hormonal medications			
Date of last exam: ____________________				Frequent heartburn or indigestion				Irregular periods			
ENT				Frequent nausea				Severe cramps with periods			
Allergic Rhinitis				Frequent or recurrent vomiting				Abnormal vaginal bleeding or spotting (not with periods)			
Frequent sore throats				Vomiting blood				Abnormal pap test			
Recent hearing change				Frequent or recurrent diarrhea				***RESPIRATORY***	**Y**	**N**	**O**
Hearing aids				Constipation				Frequent cough			
Ringing in your ears				Hemorrhoids				Cough up sputum or phlegm			
Dentures				Blood in stool				Cough up blood			
Sores in mouth				Black stools				Short of breath at rest			
Frequent nose bleeds				Use laxatives frequently				Short of breath with exertion			
Persistent hoarseness				Ulcers				Wheezing			
Difficulty swallowing				***Date of last colon exam:*** ____________________				Excessive snoring			
Frequent nasal congestion				***GENITOURINARY***	**Y**	**N**	**O**	***MUSCULOSKELETAL***	**Y**	**N**	**O**
Weakness in arm or leg				Get out of bed at night to urinate				Joint pains			
Frequent dizziness				If yes how many times ____________________				Joint swelling			
SKIN				History of kidney stones				Frequent backaches			
Skin lesions or change in moles				Blood in urine				Fractures			
Skin Rash				Painful urination				Dislocations			
NEUROLOGIC				***PSYCHIATRIC***	**Y**	**N**	**O**	Neck pain			
History of seizures				Depression				Back pain			
History of fainting (syncope)				Anxiety				Other:			
History of temporary paralysis				Crying Spells				***ENDOCRINE***	**Y**	**N**	**O**
History of stroke (CVA)				Change in personality				History of thyroid problems			
Frequent headaches				***LUNGS***	**Y**	**N**	**O**	Difficulty tolerating heat or cold			
ALLERGIC/IMMUNOLOGICAL				Severe shortness of breath				Recent change in skin or hair			
History of hives				Asthma or emphysema				***HEMATOLOGIC/LYMPHATIC***	**Y**	**N**	**O**
Frequent pneumonia				Coughing up blood				Easy bruising			
Removal of spleen				Tuberculosis				History of anemia			
Use of Prednisone or steroids				Frequent Cough				History of blood transfusion			
				Other: ____________________				Swollen lymph glands			
								Other: ____________________			