



Southeast Lincoln Family Medicine

BRYANLGH PHYSICIAN NETWORK
4424 S. 86th Street • Lincoln, NE 68526
402-483-8500 • Fax 402-483-8501

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 <input type="checkbox"/> 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 (✓):

- | | |
|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Feeling sad or irritable most of the time | <input type="checkbox"/> Injury causing unconsciousness |
| <input type="checkbox"/> Sleep too much or too little | <input type="checkbox"/> Seems like people are talking about you |
| <input type="checkbox"/> Feel tired a lot | <input type="checkbox"/> Seems like people want to hurt you |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Seeing or hearing things |
| <input type="checkbox"/> Eat too much or too little, gained or lost weight | <input type="checkbox"/> Difficulty with thinking clearly, concentrating or making decisions |
| <input type="checkbox"/> Feel hopeless, helpless, worthless | <input type="checkbox"/> Feeling especially important or having special powers |
| <input type="checkbox"/> Thought about or attempted hurting yourself | <input type="checkbox"/> Marriage/relationship conflicts |
| <input type="checkbox"/> Anxiety or panic attacks | <input type="checkbox"/> Family conflicts |
| <input type="checkbox"/> Difficulty relaxing | <input type="checkbox"/> Physically, mentally or sexually abused |
| <input type="checkbox"/> Feel worried | <input type="checkbox"/> Someone in family has emotional problems |
| <input type="checkbox"/> Nightmares or flashbacks | <input type="checkbox"/> Child behavior problems |
| <input type="checkbox"/> Memory problems, confusion | <input type="checkbox"/> Aging parents or family members |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Grieving |
| <input type="checkbox"/> Fears, phobias | <input type="checkbox"/> Cultural/social adjustment |
| <input type="checkbox"/> Headaches (tension or migraines) | <input type="checkbox"/> Recent move |
| <input type="checkbox"/> So irritable or frustrated you start fights | <input type="checkbox"/> Financial stress |
| <input type="checkbox"/> So excited you didn't sleep | <input type="checkbox"/> Facing criminal charges or legal procedure |
| <input type="checkbox"/> Eating Disorder (dieting, binging, vomiting) | <input type="checkbox"/> Job or employer-related stress |
| <input type="checkbox"/> Chronic pain, low back pain, pelvic, or stomach pain | <input type="checkbox"/> Concerns with alcohol use |
| <input type="checkbox"/> High blood pressure, asthma, diabetes | <input type="checkbox"/> Drug Use |
| <input type="checkbox"/> Believe you have serious illness or many illnesses | <input type="checkbox"/> Tobacco Use |
| | <input type="checkbox"/> 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?
 How many changes were there in your life in the past year?
 How able are you to handle the stress in your life:
 Do you think that stress is affecting your health? Yes No

None	1	2	3	4	5	A lot
None	1	2	3	4	5	A lot
Well	1	2	3	4	5	Not Well

If yes, how? _____

4. In the last three months:
 Have you felt you should cut down or stop drinking:
 Has anyone annoyed you or gotten on your nerves
 by telling you to cut down or stop drinking?
 Have you felt guilty or bad about how much you drink?
 Have you been waking up wanting to have an
 alcoholic drink?
 If you take pain or nerve pills, how often do
 you run short?
 Have any family members had problems with drugs or alcohol?
 Have you ever been treated for problems with drugs and/or alcohol?

<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Quite often	<input type="checkbox"/> Very Often
<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Quite often	<input type="checkbox"/> Very Often
<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Quite often	<input type="checkbox"/> Very Often
<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Quite often	<input type="checkbox"/> Very Often
<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Quite often	<input type="checkbox"/> Very Often
<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> Yes	<input type="checkbox"/> 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												
<u>CONSTITUTIONAL</u>	Y	N	O	<u>CARDIOVASCULAR</u>	Y	N	O	<u>MEN ONLY</u>	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: _____				