Express Care Clinic/West Lincoln Family Medicine

201 Capitol Beach Boulevard, Suite 1A
Lincoln, NE 68528
402-435-0228

Adult Health History

Name: _____ Sex: M F Date: _____

Age: _____ DOB: _____ Marital Status: S M D W Occupation: _____

Spouse's Name: _____ Occupation: _____

Children's Names and Ages: _____

_____

Current Medical Problem: _____

_____

Past or Present *(on-going)* Medical Problems: _____

_____

Surgeries & Dates: _____

_____

_____

Immunization: *(give date of most recent immunization)*

Tetanus _____ Influenza _____ Pneumonia *(Pneumovax)*_____

Current Medication:	Dosage:	How Often Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Any Allergies to Medication and/or Other Substances:

_____ Type of Reaction _____
_____ Type of Reaction _____
_____ Type of Reaction _____
_____ Type of Reaction _____
_____ Type of Reaction _____

Family History: *(List relatives with any of the following problems)*

Heart Disease: _____
High Blood Pressure: _____
Diabetes: _____
Cancer: _____
Other Inherited Diseases: _____
Emotional Problems: _____

Health Habits: *(Circle most appropriate)*

Tobacco Use:	Never	Rarely	Frequently	How Long: _____
Alcohol:	Never	Rarely	Frequently	
Street Drugs:	Never	Rarely	Frequently	
Exercise:	Never	Rarely	Frequently	
Seatbelt:	Never	Rarely	Frequently	
Eating :	Poorly	Meet Daily Needs	Excessively	

Adult Health History

Have you had the following problems: *(Include both recent past and present)*

GENERAL

Poor Appetite	Yes	No
Anemia or Low Blood Count	Yes	No
Recent Weight Change	Yes	No
Sleep Difficulties	Yes	No
Unusual Fatigue or Weakness	Yes	No
Thyroid Problems	Yes	No
Diabetes/High Blood Sugar	Yes	No
Frequent Fever or Chills	Yes	No
Frequent or Unusual Lymph Glands or Lumps	Yes	No

HEAD

Frequent, Severe or Unusual Headaches	Yes	No
Recent Changes in Vision	Yes	No
Glaucoma	Yes	No
Frequent, Unusual Dizziness	Yes	No
Hearing Difficulties	Yes	No
Ringing in Ears	Yes	No
Frequent Nosebleeds	Yes	No
Difficulty Swallowing	Yes	No
Persistent Hoarseness	Yes	No

LUNGS

Worsening Shortness of Breath	Yes	No
Asthma or Emphysema	Yes	No
Frequent Cough	Yes	No
Coughing Up Blood/Phlegm	Yes	No
Tuberculosis	Yes	No
Recurrent Pneumonia or Bronchitis	Yes	No

HEART

Heart Murmur	Yes	No
History of Heart Failure	Yes	No
Waking Up at Night Because of Shortness of Breath	Yes	No
High Blood Pressure	Yes	No
Rheumatic Fever	Yes	No
Chest Pain of Pressure	Yes	No
Heart Attack	Yes	No
Irregular Heartbeat	Yes	No
Swelling in Legs	Yes	No
Severe Calf Pain When Walking	Yes	No
Racing Heart	Yes	No

NEUROLOGIC

Seizures or Epilepsy	Yes	No
Previous Stroke	Yes	No
Numbness of Face, Arm or Leg	Yes	No
Weakness of Face, Arm, or Leg	Yes	No
Fainting or Loss of Consciousness	Yes	No

DIGESTIVE TRACT

Indigestion or Hearburn	Yes	No
Ulcers	Yes	No
Frequent Unusual Abdominal Pain	Yes	No
Vomiting Blood	Yes	No
Hepatitis or Liver Problems	Yes	No
Gallbladder Problems	Yes	No
Frequent Diarrhea	Yes	No
Hemorrhoids	Yes	No
Rectal Bleeding	Yes	No
Black Tarry Bowel Movements	Yes	No
Recent Change in Bowel Habits	Yes	No

URINARY

Bladder or Kidney Infection	Yes	No
Kidney Stones	Yes	No
Burning with Urination	Yes	No
Slow Urine Flow	Yes	No
Difficulty Starting Urine	Yes	No
Blood in Urine	Yes	No
Venereal Disease	Yes	No

GENITALIA

Men

Prostate Problem	Yes	No
Discharge from Penis	Yes	No
Lump in Testicles	Yes	No

Women

Breast Lump	Yes	No
Discharge From Nipple	Yes	No
Irregular Periods	Yes	No
Abnormal Vaginal Bleeding or Spotting *(not with periods)*	Yes	No
Abnormal PAP Test	Yes	No

Age of Onset of Periods:

Cycle: _____ Days *(start to start)*

Birth Control Method: _____

Number of Pregnancies: _____

Number or Children: _____

BONES / JOINTS

Painful/Swollen Joints	Yes	No
Persistent Back or Neck Pain	Yes	No

PSYCHOLOGIC

Have you Recently Thought About Suicide	Yes	No
Suicide Attempt	Yes	No
Frequent Anxiety	Yes	No
Frequent Depression	Yes	No
Job or Family Difficulty	Yes	No
Loss of Interest in Usually Stimulating Activities	Yes	No

Adult Health History

How often do you see you physician for physicals or preventative health visits? _____

What questions do you have concerning your health?

1. _____
2. _____
3. _____
4. _____
5. _____

This information is a valuable part of your health record. Thank you for spending the time to complete the questions.