North Lincoln Family Medical Center

ADULT HISTORY FORM

Name _____ Date _____
Date of Birth _____ Age _____ Place of Birth _____
Marital Status _____ Occupation _____

PRESENT PROBLEMS:

_____
_____
_____

PAST MEDICAL HISTORY:

ALLERGIES: Are you allergic to: Penicillin Yes No
Sulfa Yes No
Other Medication Yes No
If yes, what? _____
Other Allergies _____
_____

MEDICATIONS: Are you taking any medications regularly? Yes No
If yes, what? _____
_____

OPERATIONS: List any operations you have had and the date performed:

_____
_____
_____

OTHER HOSPITALIZATIONS: If you have been hospitalized for other reasons, list dates and reasons for hospitalizations:

_____
_____
_____

Please circle answers

IMMUNIZATIONS:

Did you have all your childhood immunizations? Yes No
Date of last tetanus immunizations? _____

PERSONAL HISTORY:

Do you smoke? Yes No
If yes, how much? _____

How much alcohol do you drink? Never Rarely Moderate Heavily

How much coffee or tea do you drink each day? _____

Have you used street drugs? Yes No

REVIEW OF SYSTEMS:

Have you had any of the following problems: (Include both past and present)

GENERAL:

Anemia	Yes	No
Recent weight change	Yes	No
Thyroid problems	Yes	No
Diabetes or high blood sugar	Yes	No
Frequent fever or chills	Yes	No
Frequent large lymph glands or lumps	Yes	No
Other _____	Yes	No

SKIN:

Frequent rashes	Yes	No
Changing mole	Yes	No
Other _____	Yes	No

HEAD:

Frequent headaches	Yes	No
Visual problems not corrected by glasses	Yes	No
Glaucoma	Yes	No
Frequent dizziness	Yes	No
Fainting	Yes	No
Epilepsy or seizures	Yes	No
Stroke	Yes	No
Weakness in arm or leg	Yes	No
Numbness	Yes	No
Hearing difficulty	Yes	No
Ringing in ears	Yes	No
Frequent nosebleeds	Yes	No
Frequent nasal congestion	Yes	No
Difficulty swallowing	Yes	No
Persistent hoarseness	Yes	No
Other _____	Yes	No

LUNGS:

Severe shortness of breath	Yes	No
Asthma or emphysema	Yes	No
Frequent cough	Yes	No
Coughing up blood	Yes	No
Tuberculosis	Yes	No
Other _____	Yes	No

HEART:

High blood pressure	Yes	No
Rheumatic fever	Yes	No
Chest pain or pressure	Yes	No
Heart attack	Yes	No
Irregular heart beat	Yes	No
Swelling in legs	Yes	No
Severe calf pain when walking	Yes	No
Other _____	Yes	No

GASTROINTESTINAL:

Indigestion or heartburn	Yes	No
Ulcers	Yes	No
Frequent abdominal pain	Yes	No
Vomiting blood	Yes	No
Hepatitis or liver problems	Yes	No
Gallbladder problems	Yes	No
Frequent diarrhea	Yes	No
Frequent constipation	Yes	No
Rectal problems or bleeding	Yes	No
Black tar-like bowel movements	Yes	No
Recent change in bowel habits	Yes	No
Other _____	Yes	No

URINARY:

Kidney or bladder infection	Yes	No
Kidney stones	Yes	No
Burning with urination	Yes	No
Difficulty passing urine	Yes	No
Difficulty controlling urine	Yes	No
Getting up at night to urinate	Yes	No
Blood in urine	Yes	No
Other _____	Yes	No

GENITALIA:

Men:

Prostate problem	Yes	No
Venereal disease (syphilis, gonorrhea, etc.)	Yes	No
Discharge from penis	Yes	No
Lump in testicles	Yes	No
Difficulty having erections	Yes	No
Other _____	Yes	No

Women:

Breast lump	Yes	No
Discharge from nipple	Yes	No
Venereal disease (syphilis, gonorrhea, etc.)	Yes	No
Irregular periods	Yes	No
Abnormal vaginal bleeding or spotting (not with periods)	Yes	No
Severe cramps with periods	Yes	No
Abnormal pap test	Yes	No

Last pap test was: _____

Age periods started: _____

Periods are: Heavy ❑ Medium ❑ Light ❑ Absent ❑

Date last menstrual period started: _____

Cycle: _____ days (from start to start)

Birth control method: _____

Number of full-term pregnancies: _____

Number of premature deliveries: _____

Number of abortions or miscarriages: _____

Number of living children: _____

Cesarean birth	Yes	No

BONES – JOINTS:

Painful or swollen joints	Yes	No
Persistent back or neck pain	Yes	No
Fractures and Dislocations	Yes	No
Other _____	Yes	No

	If Living		If Deceased	
FAMILY HISTORY Name	Age	Health	Age at Death	Cause
Father				
Mother				
Brothers/Sisters				
1.				
2.				
3.				
4.				
Children				
1.				
2.				
3.				
4.				

(Do not write in this space.)

Has any blood relative ever had:			Relationship	Age at Onset
Cancer	Yes	No		
Glaucoma	Yes	No		
Tuberculosis	Yes	No		
Diabetes	Yes	No		
Heart Trouble	Yes	No		
High Blood Pressure	Yes	No		
Stroke	Yes	No		
Epilepsy	Yes	No		
Emotional Problem	Yes	No		
Suicide	Yes	No		
Birth Defects	Yes	No		
Other Serious Disease	Yes	No		
Other				