Capital Medical Clinic

4701 Normal Blvd Lincoln NE 68506
Phone 402-488-5050 Fax 402-488-5001

PATIENT HISTORY FORM

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT

Your Name:_____Date of Birth:_____

TELL US ABOUT YOURSELF:

Single_____ Married _____ Divorced _____ Widowed _____ Number of Children_____

Habits: Do you smoke? No_____ Yes_____ If yes, how many packs per day?_____
If you have quit, how long ago?_____

Do you use alcohol? No_____ Yes_____ If yes, how often do you drink?_____
If you have quit, how long ago?_____
Does family or friends worry about your alcohol intake? _____

Have you ever had problems with drug use?_____

CURRENT AND PAST MEDICAL HISTORY:

Illness/Condition	Currently	Past	Date of onset	Please Explain:
Cancer of any origin	Y or N	Y or N		
Digestive disease	Y or N	Y or N		
Heart disease	Y or N	Y or N		
Diabetes	Y or N	Y or N		
High blood pressure	Y or N	Y or N		
Liver disease	Y or N	Y or N		
High cholesterol	Y or N	Y or N		
Alcohol/drug abuse	Y or N	Y or N		
Depression/psychiatric illness	Y or N	Y or N		
Genetic (inherited) disorder	Y or N	Y or N		
Other	Y or N	Y or N		

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Please list any surgeries (operations), reason for the surgery, and date of surgery:

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug allergy and type of reaction below:

MEDICATIONS: PRESCRIPTION AND NON-PRESCRIPTION (please include any over-the-counter medications such as aspirin, ibuprofen, vitamins, laxatives, herbal etc.)

Medications	Dose	How often taken

FAMILY HISTORY:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives.

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

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Please check the box if you are have any of the following symptoms:

Gastrointestinal
- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular
- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary/lungs
- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone
- ☐ swelling of ankles or legs
- ☐ pain, weakness or numbness in arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic
- ☐ history of stroke
- ☐ blackouts or loss of consciousness

General
- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat
- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary
- ☐ frequent or painful urination
- ☐ blood in urine

Skin
- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine
- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Women only
- ☐ abnormal Pap smear
- ☐ bleeding between periods

date of last mammogram_____
date of last period_____
date of late pap smear_____

Anything else?

- ☐ Are you experiencing an unusually stressful situation?
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit?

Immunizations:	**if YES, give approximate year given**	
Pneumococcal	No_____	Yes_____
Hepatitis A	No_____	Yes_____
Hepatitis B	No_____	Yes_____
Tetanus	No_____	Yes_____
Do you use seatbelts?	No_____	Yes_____

Patient Signature_____**Date**_____