

PATIENT HISTORY/ASSESSMENT FORM

Please answer all questions to the best of your ability

Practitioner: _____ Date: _____

Patient Name: _____ Date of Birth: _____ Sex: ___M___F

Address: _____ Phone: (Hm) _____ (Wk) _____

City/State/Zip: _____ Referring Physician: _____

Current Employer: _____ Current Occupation: _____

Marital Status: ___Single___ ___Married___ ___Widowed___ ___Divorced___ ___Separated___

Reason for visit today: _____

ALLERGIES: List any allergies you have to medications, foods or environment: _____

Do you have a **LATEX** sensitivity or allergy? ___Yes___ ___No___

Following a medical, surgical or dental procedure have you ever had any unexplained itching, hives, swelling, or anaphylactic reaction? ___Yes___ ___No___

Have you had symptoms such as sneezing, coughing, wheezing, rash or hives when handling rubber products, balloons, latex gloves or Band-Aid's? ___Yes___ ___No___

CURRENT MEDICATIONS: Please list all current medication (and dosage if known). Include over the counter drugs, herbal remedies, nutritional supplements, etc.: _____

HISTORY: Please indicate if you have previously or are currently experiencing any of the following problems:

Condition	Past Problem		Current Problem		Explain any current symptom or treatment
	Yes___	No___	Yes___	No___	
Anticoagulant Therapy (blood thinners)	Yes___	No___	Yes___	No___	_____
Arthritis	Yes___	No___	Yes___	No___	_____
Asthma	Yes___	No___	Yes___	No___	_____
Cancer	Yes___	No___	Yes___	No___	_____
Diabetes	Yes___	No___	Yes___	No___	_____
Heart Trouble	Yes___	No___	Yes___	No___	_____
High Blood Pressure	Yes___	No___	Yes___	No___	_____
Convulsions	Yes___	No___	Yes___	No___	_____
Lung trouble	Yes___	No___	Yes___	No___	_____
Acute infections	Yes___	No___	Yes___	No___	_____
Thyroid trouble	Yes___	No___	Yes___	No___	_____
Kidney trouble	Yes___	No___	Yes___	No___	_____
Bleeding tendencies	Yes___	No___	Yes___	No___	_____
Fatigue	Yes___	No___	Yes___	No___	_____
Skin rashes	Yes___	No___	Yes___	No___	_____
Other	Yes___	No___	Yes___	No___	_____

If yes, specify _____

Past surgeries including date: _____

Have you had any reaction to anesthesia? Yes_____ No_____

**Nebraska City
Medical Clinic**

1700 14th Avenue
Nebraska City, NE 68410
PH 402.873.4242
FX 402.873.4227

Pt. Name: _____ **DOB:** _____

Indicate if you have had the following or mark as NA (not applicable):

Flu Vaccine: Yes__ No__	Date: _____	Last menstrual period: Date: _____	NA _____
Tetanus shot: Yes__ No__	Date: _____	Mammogram: Date: _____	NA _____
Pneumovax: Yes__ No__	Date: _____	Chest X-Ray: Date: _____	NA _____

Do you use tobacco products? Yes___ No___ Quit (when?) _____
Product: _____ Amount: _____

Do you drink alcohol? Yes___ No___ Quit (when?) _____
Product: _____ Amount: _____

Do you use street/other illicit drugs? Yes___ No___ Type/Quantity _____

Do you use seatbelts? Yes___ No___

If you have children, do they use car safety seats? Yes___ No___

Within the last year have you been hit, slapped, kicked or otherwise physically injured by someone? Yes___ No___

List any hazards associated with employment: _____

Any other problems you have not previously listed? _____

FAMILY HISTORY:

Relation	Age	General Health/Diseases	If deceased, age of death (if known)
Maternal Grandparents	_____	_____	_____
Paternal Grandparents	_____	_____	_____
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
	_____	_____	_____
Sister(s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Other relative(s) with significant/similar problems to your complaint? _____

Is the person completing this form the patient? Yes___ No___

If no, state name and relationship to patient _____

PHYSICIAN REVIEW:	INITIALS _____	DATE _____
	_____	_____
	_____	_____
	_____	_____
	_____	_____