Lincoln Internal Medicine Associate

If this is your first exam or consult in this clinic, please answer all questions. If this is a re-exam, please note any changes that have occurred in the information on pages 1 & 2, then skip to pages 3 & 4 and answer all questions.

Date_______________

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name / First / Middle			Birth Date	Birth Place
Address / City / State / Zip			Home Phone	Business Phone
Occupation	**Medicare No.**	**Medicaid No.**	Sex M F	Marital Status
Insurance Co.		Insurance No.		Religion (optional)

Emergency Contact_______________ Relationship_______________

Address_______________ Phone Number_______________

Date of Last Physical Examination_______________ Doctor_______________

Family or Referring Physician_______________ Address_______________

Family History		If Living		If Deceased	
	Sex	Age	Health	Age at Death	Cause
Father					
Mother					
Siblings*					
	M F				
	M F				
	M F				
	M F				
	M F				
Spouse					
Children*					
	M F				
	M F				
	M F				
	M F				
	M F				

*Since some names may be used for men or women, please circle sex for each sibling and child.

Do you know of any blood relative who has or had: (Circle and give relationship)

Stroke ________ Epilepsy ________ Heart Attack ________ Nervous Breakdown ________

Cancer ________ Suicide ________ Stomach ulcers ________ Rheumatic heart ________

High blood pressure ________ Migraine ________ Kidney disease ________ Insanity ________

Tuberculosis ________ Asthma ________ Goiter ________ Congenital heart ________

Diabetes ________ Hay fever ________ Arthritis ________

Leukemia ________ Bleeding tendency ________ Colitis ________

PERSONAL HISTORY: (Circle)

Yes No Do you regularly smoke? Cigarettes Pipe Cigars For how many years?_______________
How much do you smoke?_______________

Yes No Do you usually drink coffee? How many cups/day?___________

Yes No Do you regularly drink alcohol? 1oz/day 2oz/day 4oz/day over 6oz/day
Beer: 1 bottle/day 2 bottles/day over 4 bottles/day
Wine:

Yes No Marijuana

Yes No Cocaine

Yes No Heroin or other street drugs

MEDICATION:

Are you presently taking any of the following Medications? (Circle)

Yes	No	Aspirin, bufferin, Anacin	Yes	No	Tranquilizers
Yes	No	Blood pressure pills	Yes	No	Weight reducing pills
Yes	No	Cortisone	Yes	No	Blood thinning pills
Yes	No	Cough Medicine	Yes	No	Dilantin
Yes	No	Digitalis	Yes	No	Shots
Yes	No	Hormones	Yes	No	Water Pills
Yes	No	Insulin or diabetic pills	Yes	No	Antibiotics
Yes	No	Iron or poor blood medications	Yes	No	Barbiturates
Yes	No	Laxatives	Yes	No	Birth control pills
Yes	No	Sleeping pills	Yes	No	Phenobarbital
Yes	No	Thyroid medicine	Yes	No	Other drugs not listed__________________

Write in the names and years of any operations you have had:

____

____

____

____

____

____

Name any drugs to which you are allergic:

____

____

____

____

____

Write in the names of any diseases you have had which required hospitalization:

____

____

____

____

____

____

____

____

Serious illnesses you have had that did not require hospitalization:

____

____

____

____

____

____

____

____

Serious injuries or accidents:

____

____

____

____

____

____

____

____

Immunizations: Influenza 20___ Rubella 20____ Tetanus 20____ Mumps 20____

Describe briefly the problems that have brought you here for this examination:

____
____
____
____
____
____
____
____
____
____
____
____

To be answered by men and women: (Circle)

Yes No Do you frequently have severe headaches? (If yes, answer the following):
Yes No Do they cause visual trouble?
Yes No Do they occur on one side of the head?
Yes No Do they awaken you at night from sleep?
Yes No Do they feel like a tight hat band?
Yes No Do they hurt most in the back of the head and neck?
Yes No Does aspirin relieve them?

Yes No Have you ever fainted?
Yes No Spells of dizziness?
Yes No Spells of weakness of an arm or leg?
Yes No Ringing in the ears?
Yes No Have you ever had a convulsion?
Yes No Double vision?
Yes No Pains in the ear?
Yes No Nosebleeds?

Yes No Do you have bleeding gums?
Yes No Do you frequently have trouble swallowing?
Yes No Do you frequently have hoarseness?
Yes No Do you frequently have a sore tongue?
Yes No Do you frequently have nausea and vomiting?

Yes No Do you have shortness of breath?
Yes No Do you have a chronic cough?
Yes No Do you have wheezing?
Yes No Have you ever coughed up blood?
Yes No Do you cough up sputum?

Yes No Have you ever had chest pain or tightness in the chest?
Yes No Does your heart pound or skip beats?
Yes No Do you sleep on more than one pillow?

Yes No Do you have stomach pain or distress?
Yes No Do you have nausea or vomiting?
Yes No Is there heartburn?
Yes No Are you bothered by gas?
Yes No Do you suffer from constipation?
Yes No Is there diarrhea or loose bowel movements?
Yes No Do you have loss of appetite?
Yes No Gain or loss of weight? How much?________________

Yes No Has there been a change in your bowel movements?
Yes No Do you have rectal pain or hemorrhoids?
Yes No Mucus in the stool?
Yes No Blood in the stool?
Yes No Blood on the toilet paper?
Yes No Black stools?
Yes No Require use of strong laxatives or enemas?
Yes No Have you ever been jaundiced or had hepatitis?

Have you had: (circle)

Yes	No	Burning when urinating?
Yes	No	Loss of control of bladder?
Yes	No	Blood in the urine?
Yes	No	Dark colored urine?
Yes	No	Trouble starting to urinate?
Yes	No	Trouble holding the urine?
Yes	No	Getting up frequently at night?
Yes	No	Passed a kidney stone?

Have you recently had: (Circle)

Yes	No	Pains in calves of legs when walking?
Yes	No	Cramps in legs at night?
Yes	No	Pain in the big toe?
Yes	No	Varicose veins?
Yes	No	Phlebitis or inflamed leg veins?
Yes	No	Swelling in the ankles?
Yes	No	Do you have aching or painful joints?
Yes	No	Swollen or reddening of joints?
Yes	No	Backache?
Yes	No	Morning stiffness?
Yes	No	Skin rashes or itching?

Yes	No	Do you have trouble sleeping?
Yes	No	Are you blue or depressed?
Yes	No	Are you nervous or anxious?
Yes	No	Have you considered suicide?
Yes	No	Do you have problems with your marriage?
Yes	No	Do you have sexual problems or questions?
Yes	No	Do you have family problems or concerns?

To be answered by MEN only: Have you ever had: (Circle)

Yes	No	Loss of sexual activity? For how long? ____________________
Yes	No	Treatment for genitals (private parts)?
Yes	No	Discharge from penis?
Yes	No	Hernia (rupture)?
Yes	No	Prostate trouble?

To be answered by WOMEN only: (circle)

Yes	No	Are you still having regular monthly menstrual periods?	
Yes	No	Have you ever had bleeding between your periods?	When? ____________________
Yes	No	Do you have very heavy bleeding with your periods?	When? ____________________
Yes	No	Do you feel bloated and irritable before your period?	
Yes	No	Are you now on or have you ever taken the birth control pill?	When? ____________________
Yes	No	Have you ever had a miscarriage?	When? ____________________
Yes	No	Have you ever had a discharge from the nipple of your breast?	When? ____________________
Yes	No	Do you regularly have pap smears?	Date of last test ____________________

How many children born alive ____________________

How many stillbirths ____________________

How many premature births ____________________

How many miscarriages ____________________

How many cesarean operations ____________________

Any complication of pregnancy ____________________

Date of last menstrual period ____________________

How many days do you bleed? ____________________

How often does your period come? ____________________