Nebraska Endocrinology Specialists
8207 Northwoods Drive, Suite 101
(82nd & Holdrege St)
Lincoln, NE 68505
PH 402-484-3440
FX 402-484-3441

ADULT HISTORY

NAME: _____ DATE: _____

Best Phone Number to reach you: _____

DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS M S W D

OCCUPATION: _____

Why are you being seen today? (Active Problems):

_____

_____

Chronic Medical Conditions (Past Medical History): Diabetes, High Blood Pressure, etc:

_____

_____

Past Surgical History:

_____

_____

Family History:	**Medical Problems**
Mother	☐ Diabetes ☐ Thyroid Problems ☐ Problems with Calcium or Parathyroid Glands Other Info:
Father	☐ Diabetes ☐ Thyroid Problems ☐ Problems with Calcium or Parathyroid Glands Other Info:
Children	☐ Diabetes ☐ Thyroid Problems ☐ Problems with Calcium or Parathyroid Glands Other Info:
Siblings	☐ Diabetes ☐ Thyroid Problems ☐ Problems with Calcium or Parathyroid Glands Other Info:

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Social History:

Are you a former smoker? Yes No If yes, date you quit? _____
Do you currently smoke? Yes No How much? _____
Do you drink alcohol? Yes No If yes, how much/how often? _____
Do you use illicit drugs? Yes No

Allergies:

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

Hospitalizations:

If you have been hospitalized for other reasons, list date and reasons:

_____

_____

Medications: Are you taking any medications regularly? Yes No
If yes, what? Please list name, dose and frequency

_____ _____ _____

_____ _____ _____

_____ _____ _____

What problems are bothering you today? (Circle Y or N)

Constitutional (General): ☐ **ALL NORMAL OR NO PROBLEMS**

Fatigue	Y/N	Fever	Y/N	Recent Weight Gain(_____lbs)
Feeling Poorly	Y/N	Chills	Y/N	Weight Loss (_____lbs)
Change in Appetite	Y/N	Sweats	Y/N	

Endocrine: ☐ **ALL NORMAL OR NO PROBLEMS**

Cold Intolerance	Y/N	Urinary Frequency	Y/N	Hot Flashes	Y/N
Hot Intolerance	Y/N	Excessive Thirst	Y/N	Other _____	

Eyes: ☐ **ALL NORMAL OR NO PROBLEMS**

Eye Pain	Y/N	Eyes Dry	Y/N	Change in Vision	Y/N
Eyes Red	Y/N	Eye Irritation	Y/N	Other _____	

ENT: ☐ **ALL NORMAL OR NO PROBLEMS**

Nasal Stuffiness	Y/N	Nasal Discharge	Y/N	Dry Mouth	Y/N
Snoring	Y/N	Neck Lump/Swelling	Y/N	Choking Sensation	Y/N
Difficulty Swallowing	Y/N	Sore Throat	Y/N	Tenderness	Y/N
Hearing Loss	Y/N	Hoarseness	Y/N	Other _____	

Patient Name: _____ DOB: _____

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Cardiovascular: ☐ **ALL NORMAL OR NO PROBLEMS**

Chest Pain/Discomfort	Y/N	Leg Pain with Exercise	Y/N	Other Extremity Pain _____	
Palpitations	Y/N	Extremity Pain	Y/N	Other_____	
Cold Hands or Feet	Y/N				

Respiratory: ☐ **ALL NORMAL OR NO PROBLEMS**

Cough	Y/N	Shortness of Breath	Y/N	Lying Flat	Y/N
Wheezing	Y/N	At night	Y/N	Other _____	
Coughing up Blood	Y/N	During Exercise	Y/N		

Gastrointestinal: ☐ **ALL NORMAL OR NO PROBLEMS**

Abdominal Pain	Y/N	Constipation	Y/N	Other _____	
Vomiting	Y/N	Diarrhea	Y/N		
Nausea	Y/N	Heartburn	Y/N		

Genitourinary:

MALE: ☐ **ALL NORMAL OR NO PROBLEMS**

Urinary Pain	Y/N	Hesitancy	Y/N	Breast Pain	Y/N
Frequency	Y/N	Testicular Mass	Y/N	Breast Tenderness	Y/N
Frequency at Night	Y/N	Erectile Dysfunction	Y/N	Breast Mass	Y/N
Incontinence	Y/N	Breast Enlargement	Y/N	Nipple Discharge	Y/N
Blood in Urine	Y/N	Kidney Stones	Y/N	Other _____	
Decreased Sex Drive	Y/N				

FEMALE: ☐ **ALL NORMAL OR NO PROBLEMS**

Urinary Pain	Y/N	Decreased Sex Drive	Y/N	Kidney Stones	Y/N
Frequency	Y/N	Pelvic Pain	Y/N	Breast Mass	Y/N
Frequency at Night	Y/N	Absence of Menses	Y/N	Nipple Discharge	Y/N
Incontinence	Y/N	Painful Menses	Y/N	Other _____	
Blood in Urine	Y/N	Abn Vaginal Bleeding	Y/N		

Musculoskeletal: ☐ **ALL NORMAL OR NO PROBLEMS**

Joint Pain	Y/N	Muscle Weakness	Y/N	Joint Stiffness	Y/N
Muscle Aches	Y/N	Joint Swelling	Y/N	Other _____	

Integumentary: ☐ **ALL NORMAL OR NO PROBLEMS**

Stretch Marks	Y/N	Excessive Hair	Y/N	Brittle Nails	Y/N
Skin Color Change	Y/N	Toenail Fungus	Y/N	Other _____	
Skin Wound	Y/N	Excessive Hair Loss	Y/N		

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Neurological: ☐ **ALL NORMAL OR NO PROBLEMS**

Headache	Y/N	Memory Loss	Y/N	Tremor	Y/N
Dizziness	Y/N	Numbness/Tingling	Y/N	Other _____	
Fainting	Y/N	Difficulty Walking	Y/N		

Psychiatric: ☐ **ALL NORMAL OR NO PROBLEMS**

Depression	Y/N	Mood Swings	Y/N	Other _____
Anxiety	Y/N	Sleep Disturbances	Y/N	

Heme/Lymph: ☐ **ALL NORMAL OR NO PROBLEMS**

Easy Bleeding	Y/N	Swollen Lymph Nodes	Y/N	Other _____
Easy Bruising	Y/N			

Allergic/Immunologic: ☐ **ALL NORMAL OR NO PROBLEMS**

Recurrent Infections	Y/N	Seasonal Allergies	Y/N	Other _____

FOR DIABETIC PATIENTS ONLY:

Date of last eye exam: _____

History of Retinopathy: Yes No

Date of last dental exam: _____

Immunizations:

Date of last Pneumovax immunization (Pneumonia): _____

Date of last Flu Vaccine: _____

Patient Name: _____ DOB: _____