Adult History

Nebraska Endocrinology Specialists
8207 Northwoods Drive, Suite 100
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PH: 402-484-3440
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Visit Date: _____ Patient Name: _____ Date of Birth: _____

Address: _____

SSN#_____ Age:_____ Email Address: _____

Marital Status: M S W D Occupation: _____ Full-time, Part-time or Retired

Home Phone Number: _____ Cell Phone Number: _____

Preferred Language: _____ Interpreter Needed? Yes / No

Primary Care Doctor: _____ Pharmacy/Location: _____

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 Other Info: ☐ Problems with Calcium or Parathyroid Glands
Father	☐ Diabetes ☐ Thyroid Problems Other Info: ☐ Problems with Calcium or Parathyroid Glands
Children	☐ Diabetes ☐ Thyroid Problems Other Info: ☐ Problems with Calcium or Parathyroid Glands
Siblings	☐ Diabetes ☐ Thyroid Problems Other Info: ☐ Problems with Calcium or Parathyroid Glands

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**

Activity Change	Y/N	Sweats	Y/N	Recent Weight Gain (____lbs)	
Appetite Change	Y/N	Fatigue	Y/N	Weight Loss (____lbs)	
Chills	Y/N	Fever	Y/N		

HENT: ☐ **ALL NORMAL OR NO PROBLEMS**

Congestion	Y/N	Nasal Discharge	Y/N	Difficulty Swallowing	Y/N	Snoring	Y/N
Dental Problem	Y/N	Sinus Pain	Y/N	Hoarseness	Y/N		
Ear Pain	Y/N	Sore Throat	Y/N	Neck Lump/Swelling	Y/N		
Hearing Loss	Y/N	Tinnitus	Y/N	Neck Tenderness	Y/N		

Eyes: ☐ **ALL NORMAL OR NO PROBLEMS**

Eye Discharge	Y/N	Eyes Pain	Y/N	Sensitivity to Light	Y/N
Eyes Itching	Y/N	Eye Redness	Y/N	Change in Vision	Y/N

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

Chest Tightness	Y/N	Wheezing	Y/N
Cough	Y/N	Other _____	
Shortness of Breath	Y/N		

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

Chest Pain/Discomfort	Y/N	Leg Pain with Exercise	Y/N
Palpitations	Y/N	Other Extremity Pain _____	

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

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

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

Cold Intolerance	Y/N	Urinary Frequency	Y/N	Other _____	
Heat Intolerance	Y/N	Excessive Thirst	Y/N		

Genitourinary:

MALE: ☐ **ALL NORMAL OR NO PROBLEMS**

Urinary Pain	Y/N	Blood in Urine	Y/N	Breast Enlargement	Y/N
Bedwetting	Y/N	Testicular Mass	Y/N	Breast Tenderness	Y/N
Frequency	Y/N	Decrease Sex Drive	Y/N	Nipple Discharge	Y/N
Genital Sores	Y/N	Erectile Dysfunction	Y/N	Kidney Stones	Y/N

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

Urinary Pain	Y/N	Blood in Urine	Y/N	Vaginal Discharge	Y/N
Bedwetting	Y/N	Menstrual Problems	Y/N	Breast Mass	Y/N
Frequency	Y/N	Pelvic Pain	Y/N	Nipple Discharge	Y/N
Genital Sores	Y/N	Vaginal Bleeding	Y/N	Kidney Stones	Y/N

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

Joint Pain	Y/N	Difficulty Walking	Y/N	Muscle Aches	Y/N
Back Pain	Y/N	Joint Swelling	Y/N	Other _____	

Skin: ☐ **ALL NORMAL OR NO PROBLEMS**

Skin Color Change	Y/N	Excessive Hair	Y/N
Rash	Y/N	Excessive Hair Loss	Y/N
Skin Wound	Y/N	Other _____	

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

Seasonal Allergies	Y/N	Food Allergies	Y/N	Recurrent Infections	Y/N

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

Dizziness	Y/N	Numbness/Tingling	Y/N	Fainting	Y/N
Headache	Y/N	Seizures	Y/N	Tremor	Y/N
Lightheadedness	Y/N	Speech Difficulty	Y/N	Weakness	Y/N

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

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

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

Agitation	Y/N	Depression	Y/N	Sleep Disturbances	Y/N
Behavior Problem	Y/N	Hallucinations	Y/N	Suicidal Ideas	Y/N
Confusion	Y/N	Anxiety	Y/N	Other_____	
Decrease Concentration	Y/N	Self-Injury	Y/N		

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: _____

Date of last foot exam: _____