
Name

Date

Adult Health History Form

Reason for today's visit _____

Age ____ How would you rate your general health? _____

REVIEW OF SYMPTOMS: please check any current symptoms you have.

Constitutional

- ___ Recent fevers/sweats
- ___ Unexplained Weight loss/gain
- ___ Unexplained fatigue/weakness

Respiratory

- ___ Cough/Wheeze
- ___ Coughing up blood

Skin

- ___ Rash
- ___ New or change in mole

Eyes

- ___ Change in vision

Gastrointestinal

- ___ Heartburn/reflux
- ___ Blood or change in bowels
- ___ Nausea/vomiting/diarrhea
- ___ Pain in abdomen

Neurological

- ___ Headaches
- ___ Memory loss
- ___ Fainting

Ear/Nose/Throat

- ___ Problems hearing/ringing in ears
- ___ Hay fever/allergies/congestion
- ___ Trouble swallowing

Genitourinary

- ___ Painful/bloody urination
- ___ Leaking urine
- ___ Nighttime urination
- ___ Discharge: penis or vagina
- ___ Unusual vaginal bleeding
- ___ Concern with sexual functions

Psychiatric

- ___ Anxiety/stress
- ___ Sleep problems

Cardiovascular

- ___ Chest Pains/discomfort
- ___ Palpitations
- ___ Short of breath with exertion

Blood/Lymphatic

- ___ Unexplained lumps
- ___ Easy bruising/bleeding

Breast

- ___ Breast lump
- ___ Nipple discharge

Musculoskeletal

- ___ Muscle/joint pain
- ___ Recent back pain

Endo

- ___ Cold/heat intolerance
- ___ Increase thirst/appetite

MEDICATIONS: prescription and non-prescription medicines, vitamins, home remedies, herbs, etc..
List name of medication, dose and how many times per day you take it.

Allergies or reactions to medications: _____

Date of most recent **IMMUNIZATIONS:**

Hepatitis A ____ Hepatitis B ____ Flu shot ____ MMR ____ Pneumonia shot ____ Shingles Shot ____
 Meningitis ____ Tetanus(TD) ____ Tdap(tetanus & pertussis) ____ Chicken Pox shot or illness ____

HEALTH MAINTENANCE SCREENING TEST:

Lipid(cholesterol) _____ Date _____ Normal? Yes ___ No ___

Sigmoidoscopy _____ or Colonoscopy _____ Date _____ Normal? Yes ___ No ___

Women: Mammogram _____ Date _____ Normal? _____ Pap Smear _____ Date _____ Normal? _____

Dexascan (osteoporosis) _____ Date _____ Normal? _____

Men: PSA(prostate) _____ Date _____ Normal _____

Personal Medical History: Please indicate whether you have had any of the following medical problems(w/dates)

Heart disease: Specify type _____ High blood pressure _____ High Cholesterol _____ Diabetes _____
Thyroid problems _____ Asthma/Lung disease _____ Kidney disease _____ Other(specify) _____
Cancer:(specify): _____

SURGICAL HISTORY: Please list all prior operations with dates.

FAMILY HISTORY: Please indicate the current status of your immediate family members.

Please indicate family members(parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____ High Cholesterol _____
Cancer, specify type _____ High Blood Pressure _____
Heart disease _____ Stroke _____
Depression/suicide _____ Bleeding or clotting disorder _____
Genetic disorders _____ Asthma/COPD _____
Diabetes _____ Other: _____

SOCIAL HISTORY

Tobacco Use: _____ Never _____ Quit Date _____

Current smoker: packs per day _____ # years _____

Other: Pipe _____ Cigar _____ Chew _____ Snuff _____

Are you interested in quitting? _____

Alcohol Use: _____ Drinks per week _____

Is your alcohol use a concern for you or others _____

Drug Use:

Do you use illegal drugs? _____

Sexual Activity:

Are you sexually active? _____

Current Sex Partner(s)? _____ Male _____ Female _____

Birth Control Method: _____

Have you ever had a sexually transmitted disease?

OTHER CONCERNS

Caffeine Intake: _____ coffee/tea/soda _____ cups/day _____

Weight: Are you satisfied with current weight _____

Diet: How do you rate your diet? Good _____ Fair _____ Poor _____

Do you eat or drink 4 servings of dairy or soy or take calcium supplements _____

Exercise:

Do you exercise regularly? _____ If not why? _____

What kind of exercise? _____

How often do you exercise? _____ How long? _____

Safety:

Do you use a seat belt consistently? _____

Have you completed a living will or durable power of attorney for health care? _____

SOCIOECONOMIC: Occupation: _____ Employer: _____

Years of education _____ Highest Degree _____ Marital Status: _____

Spouse/Partner's Name: _____ Number of Children _____

Are you or have you served in the Military? _____ Active or retired _____

Branch of Service: _____

WOMEN'S HEALTH HISTORY: Number of Pregnancies _____ Number of deliveries _____

Number of miscarriages _____ Number of Abortions _____

Age started period _____ Age periods ended _____

Patient Information

Name: _____

Birth Date: _____

Social Security Number: _____

Address: _____

City, State and Zip: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Employer: _____

Emergency Contact: _____ Relationship: _____

Emergency phone: _____

Insurance

(Please provide this information if you are **NOT** the primary insurance holder)

Name of Insured: _____

Birth Date of Insured: _____

Employer of Insured: _____

Social Security Number of Insured: _____

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the undersigned physician. I am responsible for non-covered services. I also authorize the undersigned physician to release to my insurance carriers any information need to process all claims.

Signed by Patient or by Guardian if Minor

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS INFORMATION RELEASE AND CONSENT TO TREATMENT

I, the undersigned, authorize payment of medical benefits to Oakview Internal Medicine, P.C. for any services furnished to me by the physicians. I understand I am financially responsible to any amount not covered by my contract. I also authorize you to release my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits.

I, knowing that I have a condition requiring diagnosis, treatment, or related medical care do hereby consent to such care. Medical examination(s), operation(s), procedure(s), and/or treatment by my attending physicians(s), their assistant(s) as may be necessary in their professional judgement. I further acknowledge that no guarantees have been made to me as to the result of such care, medical examination(s), procedure(s) and /or treatment.

Signed _____

Date _____

Oakview Internal Medicine, P.C.
2727 South 144th Street
Suite 100
Omaha, Ne 68144
402-778-5600

Notice of Privacy Practice Receipt

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information.

We want to assure you that your medical/protected health information is secure with us.

This notice contains information about how we will insure that your information remains private.

As a patient you:

1. Can inspect and copy your information.
2. Can request corrections to your information.
3. Can request that your information be restricted.
4. Can request confidential communication.
5. Can obtain a report of disclosures of your information.
6. Can obtain a paper copy of this notice.

If you have a question about this notice, please feel free to contact our Privacy officer listed below.

I acknowledge that I was provided with the Notice of Privacy Practices for Oakview Internal Medicine, P.C.

Print Name: _____

Signed Name: _____

Date: _____

Oakview Internal Medicine, P.C.
2727 South 144th Street
Suite 100
Omaha, NE 68144
402-778-5600
Privacy Officer: Jill K.