LINCOLN SURGICAL GROUP, P.C. **HISTORY AND PHYSICAL**

4740 A Street – Lincoln, NE 68510 – (402) 483-7825

NAME: ______________________________________ **DATE:** __________________________

I. MEDICAL HISTORY: *****PLEASE ANSWER EACH QUESTION****

A. Do you have any chronic illnesses (ie: heart, diabetes, etc)? No ___ If yes, please list.
____
____
____

B. Operations (List surgery and year performed). No history of surgeries ____
____
____
____
____
____

C. Serious injuries/hospitalizations not previously listed:
____

D. Are you ALLERGIC to any medications? No ___ **If yes**, please list medication, date and type of reaction:____

E. Have you ever had a blood transfusion? No ___ Yes ___ **If yes**, any reaction?
____

F. Do you currently smoke? No ____ Yes, I currently smoke ___
Number of packs you smoke per day? ____ How many years have you smoked? ____
Have you **ever smoked**? No ____ Yes ___ Number of packs you smoked per day?____
How many years did you smoke?____ When did you quit smoking? _______

G. Do you drink alcohol? No ___ If yes, quantity and how often? What type?
____
____

II. FAMILY HISTORY:

	AGE (if living)	**HEALTH PROBLEMS**	**DECEASED (age/cause)**
Father	______	________________________	
Mother	______	________________________	
Sisters	______	________________________	
	______	________________________	
Brothers	______	________________________	
	______	________________________	
	______	________________________	

Is there any family history of cancer, high blood pressure, heart trouble, diabetes? Epilepsy, bleeding disorders or unusual reactions to anesthetics? No ____ If yes, please list family members, relationship and condition: ____
____
____

NAME: ___________________________________ **DATE:** _________________________

III. OTHER MEDICAL HISTORY *****PLEASE ANSWER EACH QUESTION*****

CARDIOVASCULAR — Do you now have or have you ever had trouble with your heart or blood vessels? (Stroke, dizzy spells, blood clots, heart attack, dropsy, high blood pressure, etc.)
No ___ If yes, please describe:____
____

UPPER GI – Do you now have or have your ever had any trouble with stomach or digestion? (Difficulty swallowing, heartburn, belching, ulcers, special diet, stomach or gallbladder trouble)
No ___ If yes, please describe:____
____

PULMONARY – Do you now have or have you ever had any trouble with breathing or lungs? (TB, chronic cough, emphysema, bronchitis, shortness of breath, coughing up blood, etc.)
No ___ If yes, please describe: ____
____

LOWER GI – Do you now have or have you ever had trouble with bowel functions? (Diarrhea, constipation, blood in stool, hemorrhoids, etc.) No ___ If yes, please describe:
____
____

RENAL/URINARY – Do you now have or have you ever had trouble with kidneys or bladder? (Frequent urination, getting up at night, burning, pain, blood in urine, etc.) No ___ If yes, please describe:
____
____

MUSCULOSKELETAL – Do you now have or have you ever had any trouble with bones/joints? (Arthritis, severe fractures, leg cramps with walking, etc.) No ___ If yes, please describe:
____
____

NEUROLOGICAL – Do you now have or have you ever had any neurological problems? (Stroke, seizure, headaches) No ___ If yes, please describe:___________________________
____
____

ENDOCRINE – Do you have any history of diabetes or thyroid problems or disease? No _____
If yes, please describe: ____
____

IV. FOR WOMEN ONLY – PREGNANCY HISTORY

Number of deliveries: ______ Number of miscarriages: ______Ages of Children: ______/______/______/______

Do your children have any significant health problems? No ___ If yes please describe:
____

Do you have difficulty with excessive/irregular periods or other female problems? No ___
If yes, please describe: ____
____

Age at menopause if applicable: _________________ **Thank you!** 06/2017