LINCOLN SURGICAL GROUP, P.C.
4740 A Street – Lincoln, NE 68510 – (402) 483-7825

HISTORY AND PHYSICAL

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!** 07/2021