NEW COUNSELING HEALTH HISTORY
WOMEN'S CLINIC OF LINCOLN P.C.
220 LYNCREST DRIVE LINCOLN, NE 68510

Name: _____ Date: _____ Age: _____ D.O.B.: _____
Marital Status: (circle one) **single/married/divorced/separated/widowed**
Current Physicians you see on a regular basis:
1. _____ 3. _____
2. _____ 4._____

List all Allergies (drug, food, and environmental) and Reactions you had to them
1. _____ 6._____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10._____

List all Medications that you take (prescription and over-the-counter)

NAME AND DOSE	FREQUENCY	NAME AND DOSE	FREQUENCY
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Medical History- check "yes" or "no" regarding your **OWN** history of the following:

	YES	**NO**	**DESCRIBE**
Eyes, ears, nose or throat			
Stomach/bowel (i.e. ulcers, constipation)			
Heart/circulatory problems (ie. high blood pressure or cholesterol, heart attack, stroke, blood clots)			
Lungs (i.e. asthma, pneumonia, chronic cough)			
Bladder/kidneys (i.e. incontinence, frequent infections, kidney failure)			
Skin (i.e. cancer, acne, eczema)			
Uterus/ ovaries/ vagina			
Thyroid or pancreas			
Bones, joints, or muscles			
Nervous system (i.e. seizures)			
Mental (i.e. depression, anxiety, psychiatric disorders)			
Immune system (i.e. exposure to infectious disease, STDs)			
Cancer/ chemotherapy/ radiation			
Liver			
Diabetes			
Alcohol, tobacco or street drug use (drinking, smoking etc.)			If yes, how much?

Name: _____ Date: _____ D.O.B.: _____

SURGICAL HISTORY- list any surgeries and approximate date done.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

FAMILY HISTORY- Please check those that apply to close blood-related relatives (parents, siblings, grandparents, aunts/uncles) and indicate if it is on mother or father's side of family (i.e. maternal aunt)

Heart attack		Stroke	
High Blood Pressure		High Cholesterol	
Tuberculosis		Skin Disorders	
Lung Disease		Kidney Disorders	
Arthritis		Liver Disorders	
Cancer: Colon		Seizure Disorders	
Ovary		Depression/anxiety	
Breast		Osteoporosis	
Skin		Diabetes	
Lung		Thyroid Disorders	
Other		Gynecological problems	

Please describe any other family medical problems that are not listed:

LIFESTYLE INFORMATION

What is your occupation? _____ _____
Do you exercise regularly? YES NO If yes, please describe: _____
Have you experienced physical or verbal abuse? YES NO If yes, by whom? _____
Have you had or do you currently have an eating disorder? YES NO
Do you feel you need help with nutrition/weight management? YES NO
Do you have any physical restrictions? YES NO If yes, describe: _____
List any problems or topics you would like to receive information on. We will provide brochures if they are available.

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Reason for today's exam: (briefly describe why you are here today)