PONCA TRIBE OF NEBRASKA

HEALTH HISTORY FORM - ADULT

(Please Print)

Patient's Last name: First: Middle:	Today's date: / /	Birth date: / /	HRN#

ALLERGIES:

CURRENT MEDICATIONS/DOSAGES

PAST SURGERIES/HOSPITALIZATIONS

HEALTH HISTORY OF PATIENT
Have you ever had or are currently having?

YES	NO	
___	____	ANEMIA
___	____	ARTHRITIS
___	____	ASTHMA
___	____	BREAST DISEASE
___	____	BRONCHITIS OR PNEUMONIA
___	____	CANCER
___	____	DENTAL PROBLEMS
___	____	DIABETES MELLITUS
___	____	DRINKING OR DRUG PROBLEMS
___	____	EMPHYSEMA
___	____	EPILEPSY/SEIZURE DISORDERS
___	____	GERMAN MEASLES
___	____	GLAUCOMA OR CATARACTS
___	____	GOUT
___	____	HAYFEVER/SEASONAL ALLERGIES
___	____	HEARING PROBLEMS
___	____	HEART DISEASE
___	____	HEMORRHOIDS
___	____	HIGH BLOOD PRESSURE
___	____	HIGH CHOLESTROL/TRIGLYCERIDES
___	____	KIDNEY DISEASE (CHRONIC)
___	____	LIVER DISEASE
___	____	MENTAL OR EMOTIONAL PROBLEMS
___	____	POLYPS/GROWTH IN BOWELS
___	____	RHEUMATIC FEVER
___	____	STOMACH OR DUODENAL ULCERS
___	____	SUICIDE ATTEMPT
___	____	THYROID DISEASE
___	____	TUBERCULOSIS (TB)
___	____	SEXUALLY TRANSMITTED DISEASE
___	____	VISION PROBLEMS
___	____	WEIGHT PROBLEMS
___	____	OTHER (please list):

_____
_____
_____

PLEASE LIST ANY ADDITIONAL PROBLEMS, CONCERNS, OR INFORMATION ABOUT YOU OR YOUR FAMILY THAT YOU WOULD LIKE THE HEALTH CARE PROVIDER TO KNOW ABOUT:

_____
_____
_____
_____
_____

FAMILY HISTORY OF PATIENT

YES	NO	
___	____	ANEMIA
___	____	ARTHRITIS
___	____	BIRTH DEFECT
___	____	BLEEDING TENDENCY
___	____	CANCER
___	____	DEAFNESS
___	____	DIABETES MELLITUS
___	____	DRINKING OR DRUG PROBLEMS
___	____	EPLIEPSY/SEIZURES
___	____	GLAUCOMA
___	____	HEART ATTACK OR HEART DISEASE
___	____	MENTAL/EMOTIONAL PROBLEMS
___	____	NERVE OR MUSCLE DISEASE
___	____	OBESITY
___	____	STROKE
___	____	SUICIDE/ATTEMPTED SUICIDE
___	____	TUBERCULOSIS
___	____	OTHER (please list):

_____
_____
_____

DATE OF LAST TETNAUS BOOSTER? _____

DATE OF LAST BLOOD CHOLESTROL TEST? _____

LIST ANY INJURIES OR FRACTURES (ALSO LIST AGE):
_____
_____
_____

LIST ANY OPERATIONS (ALSO LIST AGE):
_____
_____
_____

LIST ANY HOSPITALIZATIONS (ALSO LIST AGE):
_____
_____
_____

FOR WOMEN:
DATE OF LAST PAP SMEAR AND PELVIC EXAM? _____

DATE OF LAST MAMMOGRAM? _____

PATIENT SIGNAURE: _____

DATE: _____