BUTLER COUNTY CLINIC, PC
336 S 9TH St.
David City, NE 68632
P: 402-367-3193 F: 402-367-3261

HEALTH HISTORY

Name ______________________ **Date** ______________

DOB ______________ **Age** ______________ **Marital Status: M S W D**

Personal Physician ______________________

1. **REASON** for today's visit: ______________________________

2. **SERIOUS INJURIES/ILLNESSES – SURGERIES – HOSPITALIZATIONS**

Year Explanation	Physician Comments

MEDICATIONS – List medications you are currently taking, including dosage and frequency:

4. **ALLERGIES –** List allergies to medications, foods, latex or environment:

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5. FAMILY HISTORY

	Father	Present Health or age and cause of death	Mother	Present Health or age and cause of death

	Alive	Health	Deceased	Health	Cause of Death and Age
Brothers					
Sisters					
Children					

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **PARENTS, SIBLINGS OR GRANDPARENTS**:

- ▫ Allergy
- ▫ Arthritis
- ▫ Asthma
- ▫ Bleeding tendency
- ▫ Cancer: Type __________
- ▫ Chemical dependency
- ▫ Diabetes
- ▫ Gout
- ▫ Heart Disease
- ▫ High Blood Pressure
- ▫ Kidney Disease
- ▫ Stroke
- ▫ Tuberculosis
- ▫ Other___________________________

6. HEALTH HABITS – Check (✓) which substances along with the frequency and amount used:

	Never Used	Every Day (Indicate amount)	Some Days (indicate amount and how often)	Formerly (in the past)
Caffeine				
Tobacco				
Alcohol				
Illicit Drugs				
Supplements				
Other:				

		Date
Are your Immunizations up to date?	**Tetanus**	
	Influenza	
	Pneumovax if Age > 65	
	Zostavax (Shingles) if Age > 50	

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Have you had a colonoscopy?	▫ **Normal**	▫ **Abnormal**	**Date: ______________________**
Have you had a mammogram (females)?	▫ **Normal**	▫ **Abnormal**	**Date: ______________________**
Have you had a pap smear (females)?	▫ **Normal**	▫ **Abnormal**	**Date: ______________________**

7. **MEDICAL HISTORY - Circle any conditions you currently have or have experienced in the past:**

Abortion	Chemical Dependency	Hypertension	Psychiatric Care
Alcoholism	Chicken Pox	Kidney Disease	Rheumatic Fever
Anemia	Diabetes	Liver Disease	Scarlet Fever
Anorexia	Emphysema	Measles	Sexually Transmitted Disease
Appendicitis	Epilepsy	Migraine Headaches	Stroke
Arthritis	Glaucoma	Miscarriage	Suicide Attempt
Asthma	Goiter	Mononucleosis	Thyroid Problems
Bleeding Disorders	Gout	Multiple Sclerosis	Tonsillitis
Breast Lump	Heart Disease	Mumps	Tuberculosis
Bronchitis	Hepatitis	Pacemaker	Typhoid Fever
Bulimia	Hernia	Pneumonia	Ulcers
Cancer	Herpes	Polio	Vaginal Infections
Cataracts	High Cholesterol	Prostate Problems	

Other: ____