



**CONFIDENTIAL MEDICAL HISTORY
UNIVERSITY OF NEBRASKA-LINCOLN**

PLEASE PRINT

Name _____
Last First Middle

UNL ID # _____ Date of Birth _____ Age _____ Sex _____

Lincoln Address _____ (_____) _____
Street Zip Code Telephone

Permanent Address _____ (_____) _____
Street City State Zip Code Telephone

Person to Notify in Case of Emergency _____ (_____) _____
Name Address Telephone

Family Physician _____ (_____) _____
Name Address Telephone

Medical History

Have you had any of the following?

Cardiovascular/Pulmonary	Yes	No	Orthopedics	Yes	No	Wisdom Teeth Extraction		
Asthma			Arthritis			Previous Hospitalizations		
Heart Disease			Fractures			Prior Surgery _____		
Heart Murmur			Dermatology	Yes	No	Infectious Diseases	Yes	No
High Blood Pressure			Eczema			Chicken Pox		
Pneumonia			Hives			Hepatitis – Type: _____		
Rheumatic Fever/Rheumatic Heart Disease			Psoriasis			HIV Infection		
Thrombophlebitis (Blood Clots)			Hematology/Oncology	Yes	No	Infectious Mononucleosis (Mono)		
			Anemia			Malaria		
Endocrine	Yes	No	Blood Disorders			Mumps		
Adrenal Disorders			Cancer			Tuberculosis		
Diabetes			Radiation Therapy			Typhoid Fever		
Thyroid Disorders			Neurological	Yes	No	Sexually Transmitted Diseases		
Renal	Yes	No	Convulsions			Other		
Kidney or Bladder Disease			Head Injury			Social History	Yes	No
Kidney Transplant			Headaches			Do you drink alcohol?		
EENT	Yes	No	Multiple Sclerosis			Do you exercise regularly?		
Eye Disorders (other than glasses or contacts)			Muscular Dystrophy			Do you smoke or use smokeless tobacco?		
			Stroke/TIA					
Hearing Loss			Other	Yes	No	Do you take herbal medicines?		
Nasal Allergies (Hayfever)			Anorexia			Do you take vitamins?		
Sinus Infections			Bulimia			OB History (enter #)		
GI	Yes	No	Depression			Pregnancies _____ Miscarriages _____		
Chronic Colitis			Surgical History/Hospitalizations	Yes	No	Live Births _____ Now Living _____		
Gallbladder Disease			Appendectomy			Abortions _____ Still Born _____		
Gastric Ulcer			Ear Tubes			Current medications (include birth control pills, acne meds, etc.):		
Irritable Bowel Syndrome			Gallbladder Removal					
Jaundice (other than newborn)			Knee ACL Repair <input type="checkbox"/> Left <input type="checkbox"/> Right					
Liver, Stomach, or Bowel Disease			Knee Arthroscopy <input type="checkbox"/> Left <input type="checkbox"/> Right			Please list medication allergies:		
			Ovarian Cyst Removal					
Peptic Ulcer			Tonsillectomy			Have you had any reactions to bee stings, dyes, food, latex, etc.? If so, what were your symptoms?		
Comment on all "yes" answers:								

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Family History				
Occupation	Age if Living	Significant Illnesses or Cause of Death	Age & Year of Death	
Father				Did/does your (father, mother, sister, brother, maternal/paternal grandparent) have any of the following? <input type="checkbox"/> Alcoholism <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Stroke <input type="checkbox"/> Kidney Disease Cancer (Type) _____
Mother				
Siblings				
Spouse				
Children				