JEFFERSON COMMUNITY
Health & Life
FAIRBURY CLINIC

Patient Personal History

825 22nd Street, Fairbury, NE 68352

Phone: 402-729-3361 Fax: 402-729-4010

Last Name: **First Name:** **Middle Initial:** **DOB: / /**

ALLERGIES AND REACTIONS:

PRESENT MEDICATIONS:

Medication	Dose	Frequency

SOCIAL HISTORY:

Marital Status: ___ Married ___ Divorced ___ Single ___ Widowed ___ Significant Relationship ___ Other

Spouse/Significant Others Name: _____

Number of Children: ___ Their ages and health status_____

Power of Attorney's Name (if you have one) _____

Do you have an Advance Directive or DNR order? ___Yes ___No If yes may we please have copies? _____

Occupation (current or prior): _____

Primary Care Provider: _____ Other Specialists:_____

Tobacco use: ___ Never Smoked ____ Former Smoker ___ Current Smoker ___ Other (vape/pipes/chew)

If ever a tobacco user, describe average daily use and for how long: _____

Recreational use of drugs? Yes___ No___

Have you ever taken med for tobacco cessation? Yes ___ No___ Would you be interested in quitting?_____

Typical number of alcoholic drinks ___ per day/week/month/year (circle one)

Environmental or Occupational exposures (asbestos, radiation, inhaled dust, etc.) _____

MEDICAL HISTORY: (Previous Operations)

Procedure	Surgeon	Location	Month/Year

Do you currently have, or previously had, any of the following? (Circle those that apply)

Arthritis	Diabetes	High Cholesterol	Liver Disease	Asthma	COPD
Obesity	Thyroid Disorders	High Blood Pressure	Heart Disease	Seizure Disorder	CVA/Stroke
Colon Diseases	Depression	Kidney Disease-CKD	Pacemaker	Heart Arrhythmia	DVT/PE/Clots
Stomach Ulcers	Prior Chemo/Radiation Therapy	Other Psychiatric Disorders:_____			

Any other disorders:_____

FAMILY HISTORY:

Please list any first-degree (siblings, parents, children) or second-degree (grandparents, aunts, uncles, grandchildren, nieces, nephews, half siblings) with a history of cancer, blood diseases, bleeding or clotting disorders:

Relationship	Maternal	Paternal	Cancer Site/Disorder	Age at diagnosis
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List any other distant relatives with cancer or blood diseases:

_____

_____

_____

Do you know any blood relative who had or currently has: (circle and give relationship)

Heart Disease_____	High Blood Pressure _____	Stroke_____
Diabetes_____	Intestinal Disease_____	Seizure Disorder_____
Depression_____	Kidney Disease_____	Lung Disease_____

Any diseases you think tend to run in the family?_____

DATES OF:

Colonoscopy ___/___/___	Flu Shot ___/___/___	Pneumococcal 23 ___/___/___
Pneumovax 13___/___/___	Dexa ___/___/___	Shingles___/___/___
Tetanus (TDAP) ___/___/___	Diabetic Eye Exam ___/___/___	Diabetic Foot Exam ___/___/___
Last Fall ___/___/___	Mammogram ___/___/___	Pap ___/___/___

FEMALE PATIENTS ONLY:

Are you having regular menstrual cycles? Yes___ No___ Date/Year of last menses: _____

Are you menopausal? Yes___ No___ Are you beginning menopause? Yes___ No___

Number of pregnancies:_____ Any significant complications or difficulties?_____

Are you currently on Birth Control? Yes___ No___ If yes what type? _____

Are you currently on hormone supplements? Yes___ No___

Today's date: ____/____/____