5640 S 84th Street, Suite 100
Lincoln, NE 68516
Phone: 402-486-0602

Date: _______/________/________ Name: ____________________________________

Circle YES or NO

Have you or any immediate family member ever been told you have:

	Self	Family
Cancer?	Yes .. No	Yes .... No
Diabetes?	Yes .. No	Yes .... No
High blood pressure?	Yes .. No	Yes .... No
Heart disease?	Yes .. No	Yes .... No
Angina/chest pain?	Yes .. No	Yes .... No
Stroke?	Yes .. No	Yes .... No
Osteoporosis?	Yes .. No	Yes .... No
Osteoarthritis?	Yes .. No	Yes .... No
Rheumatoid arthritis?	Yes .. No	Yes .... No

In the past 3 months have you had or do you experience:

A change in your health?	Yes .... No
Nausea/vomiting?	Yes .... No
Fever/chills/sweats?	Yes .... No
Unexplained weight change?	Yes .... No
Numbness or tingling?	Yes .... No
Changes in appetite?	Yes .... No
Difficulty swallowing?	Yes .... No
Changes in bowel or bladder function?	Yes .... No
Shortness of breath?	Yes .... No
Dizziness?	Yes .... No
Upper respiratory infection?	Yes .... No
Urinary tract infection?	Yes .... No

Do you have a pacemaker? ....Yes .... No

Circle YES or NO

Do you have a history of:

Allergies/asthma?	Yes ... No
Headaches?	Yes ... No
Bronchitis?	Yes ... No
Kidney disease?	Yes ... No
Rheumatic fever?	Yes ... No
Ulcers?	Yes ... No
Sexually transmitted disease?	Yes ... No
Seizures?	Yes ... No

Any other medical condition? ____________

Are you currently:

Pregnant?	Yes ... No
Depressed?	Yes ... No
Under stress?	Yes ... No

Are your symptoms: (check one)
___ Getting worse ___The same ___ Improving

How are you able to sleep at night: (check one)
___ Fine ___Moderate difficulty ___ Only with medication

Do you or have you smoked tobacco? Yes No
If yes, ______ packs for ______ years
Last tobacco use: ________________________

Date of last physical exam? __________________

History of Falls in last 12 months: Yes No
Injuries from falls: _________________________

List of previous surgeries and year:

____

____

List medications you are currently taking:

____

____