

AUM NURSING CARE CENTER
ADOLESCENT/ADULT HEALTH HISTC

Date 1/17/09

Name (J.) Michael Burger

1. What is the reason for your visit today? wax in ears / possible ear infection
2. Is there anything about you and your health that we need to know? _____
- *3. List medicine, drugs, or food you are allergic to: may be allergic to penicillin; I don't tolerate
- *4. List any medicines or drugs you take: Lipitor (20 mg.) Asiphex (20 mg.)
baby aspirin codorn
5. Have YOU or anyone in your family had any of the following: (circle)

heart disease

high blood pressure

stroke

diabetes/sugar

blood problem or disease

cancer

tuberculosis

birth defects

mental retardation

nerve or mental problems

asthma

died before age 50

other "family" disease

6. Have you ever been in the hospital? NO Why? _____
7. Have you ever had surgery? YES Why? gum surgery
8. Have you ever had a serious accident? NO
9. Have you had serious or recent problems with:

ears or throat

NO YES

cough

NO YES

kidneys

NO YES

gallbladder

NO YES

allergies

NO YES

thyroid

NO YES

weight loss

NO YES

liver

NO YES

lung infections

NO YES

skin problems

NO YES

ulcers

NO YES

depression

NO YES

headaches

NO YES

(kidney stones)

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
- *12. Have you ever smoked cigarettes or used smokeless tobacco? NO YES
- If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?
- How much smokeless tobacco do you use a day? _____
- *13. How often do you drink beer, wine, wine coolers, or liquor?
- Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week
- If you drink beer, wine, wine coolers, or liquor, do you have:
- (less) (more) than 5 drinks a day?

- *14. Have you ever used marijuana, cocaine, crack or other drugs? NO YES
- *15. Have you ever used I.V. drugs? NO YES
16. Have you ever had a blood transfusion? NO YES
17. Do you have any tattoos? NO YES
18. Have you ever been treated for a venereal disease? NO YES
19. Have you had more than one sex partner in the past 5 years? NO YES
20. Have you ever had sex with a member of your own sex? NO YES
21. Have you had or been around anyone with hepatitis? NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? _____ Date of your last period? _____
- How often do you have your periods? _____ Are they regular? _____
- How many days do they last? _____
- Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
- Do you check them regularly? YES NO
- *C. How many times have you ever been pregnant? _____ How many children are living? _____
- Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES
- Were any of your children premature? NO YES
- How old were you when your first child was born? _____
- D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES;
- diaphragm? NO YES
- E. Did you have problems with any of these methods? NO YES
- F. Have you ever had an abnormal PAP smear? NO YES