CONSULTANTS
IN INFECTIOUS DISEASE
A Culture of Compassion

Steve Rademacher, MD
James Nora, MD
Daniel Smith, MD
Cindy Pieper, PA-C
Taylor Straube, APRN-NP
Claire Green, APRN-NP

New Patient Health History

Patient Information
Patient's Name (Last, First, MI) _____ _____ _____
Date of Birth ___ /___ /___

Pharmacy Information
Pharmacy Name _____
Address 1 _____ Address 2 _____
City _____ State _____ Zip Code _____
Phone _____

Referral Information
Who referred you to our office? _____ Phone _____
Reason you are here today? _____

Other Health Care Providers you have seen for the same thing? _____

Primary Care Physician
Name _____ Phone _____ Date of last visit ___ /___ /___

MEDICATIONS

Please list all prescription and non-prescription medicines, vitamins, home remedies, birth control, and herbs.

MEDICATION	DOSE	HOW MANY TIMES PER DAY	HOW LONG HAVE YOU TAKEN

CONSULTANTS
IN INFECTIOUS DISEASE
A Culture of Compassion

Steve Rademacher, MD
James Nora, MD
Daniel Smith, MD
Cindy Pieper, PA-C
Taylor Straube, APRN-NP
Claire Green, APRN-NP

ALLERGIES

MEDICATION	REACTION	AGE AT WHICH THIS OCCURRED

Please list any food, tape, and latex or other non-medication allergies _____
_____
_____

SOCIAL HISTORY

Occupation _____ Employer _____
How long have you done this type of work? _____ Previous line of work? _____
Years of Education / Degree _____ Where did you attend school? _____
Spouse / Partner Name _____ Number of Children / Ages _____
Does anyone live at home with you? If so, who? _____
Hobbies _____ Pets _____
Do you have any culinary habits? (raw fish, raw steak) _____

IMMUNIZATION / TRAVEL HISTORY

Have you ever had any of the following immunizations? If so, when?
Hepatitis A _____ Hepatitis B _____ Influenza (flu) _____ Measles _____
Rubella _____ Tetanus (Td) _____ Pneumonia (pneumovax) _____
Varicella (chicken pox) _____ or Illness _____
PPD (Tuberculosis skin test) _____ Have you ever tested positive? _____
If yes, when were you treated? _____ How long were you treated? _____
How long have you lived in Nebraska? _____
Previous Cities & States _____
Have you ever traveled outside the United States? If so, when and where did you travel? _____
_____

CONSULTANTS
IN INFECTIOUS DISEASE
A Culture of Compassion

Steve Rademacher, MD
James Nora, MD
Daniel Smith, MD
Cindy Pieper, PA-C
Taylor Straube, APRN-NP
Claire Green, APRN-NP

RISK ASSESSMENT

Tobacco Use

- ☐ Never
- ☐ Quit, When _____ How Long? _____
- ☐ Cigarette packs per day _____ How long? _____
- ☐ Pipe
- ☐ Chewing Tobacco
- ☐ *Are you interested in information about quitting?*

Alcohol Use

- ☐ Do you drink alcohol? Number of drinks per week? _____
- ☐ Is your alcohol use a concern to you or others? Are you interested in trying to quit? _____

Drug Use

- ☐ Do you use recreational drugs? If YES, how long have you been using? _____
- ☐ Marijuana?
- ☐ Cocaine?
- ☐ Methamphetamines? Do you share needles? _____
- ☐ *Are you interested in quitting?*

Advanced Directives

- ☐ Do you have a Living Will or Durable Power of Attorney?
- ☐ Sexual activity: Are you sexually active?
- ☐ Do you have multiple sex partners?

Current sex partner(s) is/are:

- ☐ Male
- ☐ Female
- ☐ Both

Do you practice safe sex?

- ☐ Yes. What methods do you use? _____
- ☐ No.

Have you ever had a sexually transmitted disease?

- ☐ Yes. If so, when? _____ Please circle which one? Gonorrea, Syphilis, Chlamydia
- ☐ No.

Have you ever been tested for HIV?

- ☐ Yes. When was the last test? _____ Was it positive or negative? _____
- ☐ No.

CONSULTANTS
IN INFECTIOUS DISEASE
A Culture of Compassion

Steve Rademacher, MD
James Nora, MD
Daniel Smith, MD
Cindy Pieper, PA-C
Taylor Straube, APRN-NP
Claire Green, APRN-NP

PAST MEDICAL HISTORY

YEAR	OPERATION OR ILLNESS	HOSPITAL

Do you have problems with any of the following? Circle YES or NO

Y	N	Change in appetite	Y	N	Sputum production
Y	N	Chills	Y	N	Wheezing
Y	N	Fatigue	Y	N	Chest pain
Y	N	Fever	Y	N	Difficulty lying flat
Y	N	Headache	Y	N	High blood pressure
Y	N	Lightheadedness	Y	N	Irregular heart rate or palpitations
Y	N	Night sweats	Y	N	Abdominal pain
Y	N	Sleep disturbance	Y	N	Constipation
Y	N	Weight gain	Y	N	Diarrhea
Y	N	Weight loss	Y	N	Hepatitis
Y	N	Allergic rhinitis	Y	N	Heartburn
Y	N	Vision changes	Y	N	Nausea and vomiting
Y	N	Decreasing hearing	Y	N	Black or bloody stool
Y	N	Ringing in ears	Y	N	Easy bruising and prolonged bleeding
Y	N	Sinus pain	Y	N	Cancer
Y	N	Sore throat	Y	N	Painful urination
Y	N	Swollen glands	Y	N	Muscle aches
Y	N	Diabetes	Y	N	Joint pain
Y	N	Thyroid disease	Y	N	Peripheral vascular disease
Y	N	Frequent urination	Y	N	Rash
Y	N	Excessive thirst	Y	N	Itching
Y	N	COPD	Y	N	History of stroke
Y	N	Asthma	Y	N	Seizure disorder
Y	N	Cough	Y	N	Tingling/numbness
Y	N	Shortness of breath at rest	Y	N	Pain

CONSULTANTS
IN INFECTIOUS DISEASE
A Culture of Compassion

Steve Rademacher, MD
James Nora, MD
Daniel Smith, MD
Cindy Pieper, PA-C
Taylor Straube, APRN-NP
Claire Green, APRN-NP

Y N Memory loss
Y N Anxiety
Y N Depressed mood

Women:

Number of pregnancies? _____
Number of births? _____
Y N Frequent urinary tract infections
Y N Genital herpes
Y N Irregular periods
Y N Painful menstruation
Y N Vaginal discharge

Men:

Y N Lumps or infection of testicles
Y N Penile discharge
Y N Premature ejaculation
Y N Enlarged prostate
Y N Trouble achieving or maintaining erection
Y N Genital herpes

FAMILY HISTORY

Have any of your relatives had any of the following? Who?

Y N Diabetes _____
Y N High blood pressure _____
Y N Heart disease _____
Y N Stroke _____
Y N Mental illness _____
Y N Cancer _____
Y N Other _____

Please list age and state of health of family. (Good, Fair, Poor) Date of death & reason.

Mother _____
Father _____
Brothers _____
Sisters _____
Children _____