

CONSULTANTS IN INFECTIOUS DISEASE

A Culture of Compassion

Steve Rademacher, MD
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ALLERGIES

MEDICATION	REACTION	AGE AT WHICH THIS OCCURRED

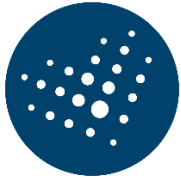
Please list any food, tape, and latex or other non-medication allergies _____

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? _____



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?

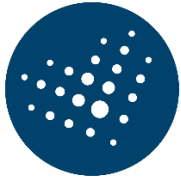
- Yes. What methods do you use? _____
- No.

Have you ever had a sexually transmitted disease?

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

Have you ever been tested for HIV?

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



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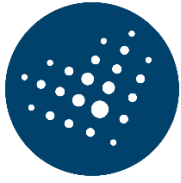
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PAST MEDICAL HISTORY

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 |



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- 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