

# Stewart Family Medicine

## ADULT HISTORY SHEET

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Name:	Date of Birth:	<b>ALLERGIES</b>
Age:	Today's Date:	A. Please list any medication (s) to which you are allergic:
<b>SOCIAL HISTORY</b>		
(please fill in the blanks or circle your answer as appropriate):		
Marital Status:    Single       Married       Separated       Divorced       Widowed		B. Please list anything else you are possibly allergic to:
Do you have any children?	If yes, please list the name(s) of your child(ren):	
<b>FAMILY HISTORY</b>		
<b>LIVING RELATIVES &amp; AGE</b>	<b>SPECIFY CHRONIC ILLNESS(ES)</b>	
Grandfather (maternal)		
Grandmother (maternal)		
Grandfather (paternal)		
Grandmother (paternal)		
Father		
Mother		
Sibling (s)		
<b>DECEASED RELATIVES &amp; AGE AT DEATH</b>	<b>CAUSE OF DEATH</b>	
Grandfather (maternal)		
Grandmother (maternal)		
Grandfather (paternal)		
Grandmother (paternal)		
Father		
Mother		
Sibling (s)		
<b>RISK FACTORS</b>		
1. Do you now or have you ever smoked cigarettes? Yes No # of packs _____ How many years have you smoked? _____		
2. Do you drink alcohol? Yes No Amount consumed in one week: _____		
3. Please estimate the amount of caffeine you consume in a day: _____		
4. Do you have any drug habits? Yes No Explain: _____		
5. Have you ever had a high cholesterol level? Yes No		
6. Do you exercise regularly? Yes No Method: _____		
7. Are you overweight? Yes No		
<b>GENERAL MEDICAL HISTORY</b>		
<b>ILLNESSES:</b> Please circle any of the following illnesses that you have had:		
Anemia	Blood Transfusions	Kidney Stones
Hernia	Bleeding Disorders	Skin Disease
Jaundice	High Blood Pressure	Pneumonia
Diabetes	Asthma or Hay fever	Convulsion
Colitis	Nervous Breakdown	Heart Murmur
Arthritis	Gall Bladder Disease	Bone Disease
Hepatitis	Blood Clots or Phelebitis	Back Trouble
Ulcer	Varicose Veins	Drug Reaction
Cancer	Heart Disease	Migraine
Allergies	Other _____	
<b>MEDICATION:</b> Please circle any of the following you are currently taking (or have taken):		
Cortisone or Steroids	Pain Medicine	Arthritis Medicine
Blood Pressure	Diuretics	Tranquilizers
Thyroid	Hormones	Nerve Pills
Heart Medicine	Sleeping Pills	Diet Pills
Antibiotics	Asthma Medicine	Other
<b>HOSPITALIZATION:</b> Please list any hospitalizations you have had (excluding childbirth)		
<b>Year</b>	<b>Diagnosis</b>	<b>Hospital (include City &amp; State)</b>

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<b>SURGERY:</b> Please circle any operations you have had on any of the following:		
Appendix	Kidney	Breast
Gallbladder	Varicose	Chest
Thyroid	Hernia	Hemorrhoids
Tonsils	Tumor	Other _____
<b>SYSTEM REVIEW:</b> Please circle any of the following symptoms that you have or had:		
<b>1. GENERAL HEALTH</b> Fever Night Sweats Hot Flashes Significant Weight Loss Loss of Appetite Significant Weight gain	<b>2. ENDOCRINE GLANDS</b> Goiter Excessive Thirst Excessive Hunger Underactive Thyroid Overactive Thyroid	<b>3. SKIN</b> Rash Boils Sores Eczema Moles Have the moles changed color or size? Y/N
<b>4. LYMPH NODES</b> Neck Swelling Armpit Swelling Groin Swelling Glaucoma	<b>5. EYES</b> Wear Glasses Vision Changes Eye Pain Blurred Vision	Wear Contacts Double Vision Blind Vision Drainage from Ears
<b>6. EARS</b> Difficulty Hearing Pain in Ears Frequent Ear Infections	<b>7. NOSE AND SINUSES</b> Frequent Nosebleeds Sinus Congestion Hay Fever Previous Chest X-RAY Positive TB Skin Test Coughing Up Blood Chronic Bronchitis Heart Murmur Palpitation(s)/ Heart Thump Vein Problems in Legs	<b>8. MOUTH AND THROAT</b> Sores in the Mouth Hoarseness Problems with Tonsils
<b>9. LUNGS</b> Cough Wheezing Emphysema Chest Discomfort Rapid Heart Beat Irregular Heart Beat	Shortness of Breath Ulcers Blood or Mucus in Stools Rectal Pain Bloating After Meals Heavy Drinking Frequent Use of Antacids Problem Swallowing	<b>10. HEART AND BLOOD VESSELS</b> Chest Pain Wake Up Short of Breath Sleep on 2 or More Pillows Rheumatic Fever Swelling in Ankles Cramps in Legs Get Winded Easily Liver Disease Constipation Hemorrhoids Black, Tarry Stools Change in Bowel Habits
<b>11. ABDOMINAL ORGANS</b> Abdominal Pain Heartburn/Indigestion Vomiting Blood Diarrhea Hepatitis Jaundice Gallstones	<b>12. KIDNEYS OR BLADDER</b> Difficult/Painful Urination Very Frequent Urination Kidney Disease Protein in Urine Can't Hold Urine	<b>13a. GENITALS (MEN ONLY)</b> Sores on Penis Prostate Trouble Impotence Discharge From Your Penis Difficulty Voiding Venereal Disease
<b>13b. GENITALS (WOMEN ONLY)</b> Abnormal Pap Swear Irregular Periods Pain on Intercourse Breast Lumps Venereal Disease Unusual Vaginal Discharge	Pelvic Pain Problems with Sex Abnormal Bleeding Nipple Discharge <b>Please indicate the number of:</b> Pregnancies _____ Normal Deliveries _____ Premature Deliveries _____ Miscarriages _____ Abortions _____	<b>14. MUSCLES, BONES AND JOINTS</b> Deformities Pain in Joints Swelling in Joints Muscle Weakness Chronic Pain in Back Gout
<b>13c. GENITALS (WOMEN ONLY)</b> Age when menstrual period began: _____ Date last period began: _____ Living Children: _____ _____ Date of last pap smear: _____ Birth Control Method: _____ Do you know how to examine your breast?      Yes or No	<b>15. NERVOUS SYSTEM</b> Frequent/Severe Headaches Head Injury Seizures/Fits/Convulsions/Epilepsy Weakness Difficulty Sleeping Severe Anxiety Numbness or Tingling Suicidal Thoughts Desire Psychiatric Help Feel Sad or Depressed	
<b>16. IMMUNIZATIONS</b> Please give the year of last injection for the following: Tetanus _____ Tuberculosis Skin Test _____ **If you've never had one or both of the tests, please indicate so here: _____		