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:	**ALLERGIES**
Age:	Today's Date:	A. Please list any medication (s) to which you are allergic:
SOCIAL HISTORY		
(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):	
FAMILY HISTORY		

LIVING RELATIVES & AGE	**SPECIFY CHRONIC ILLNESS(ES)**
Grandfather (maternal)	
Grandmother (maternal)	
Grandfather (paternal)	
Grandmother (paternal	
Father	
Mother	
Sibling (s)	
DECEASED RELATIVES & AGE AT DEATH	**CAUSE OF DEATH**
Grandfather (maternal)	
Grandmother (maternal)	
Grandfather (paternal)	
Grandmother (paternal	
Father	
Mother	
Sibling (s)	

RISK FACTORS

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

GENERAL MEDICAL HISTORY

ILLNESSES: 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_____	

MEDICATION: 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

HOSPITALIZATION: Please list any hospitalizations you have had (excluding childbirth)

Year	Diagnosis	Hospital (include City & State)

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SURGERY: Please circle any operations you have had on any of the following:

Appendix	Kidney	Breast
Gallbladder	Varicose	Chest
Thyroid	Hernia	Hemorrhoids
Tonsils	Tumor	Other_____

SYSTEM REVIEW: Please circle any of the following symptoms that **you have or had:**

1. GENERAL HEALTH
Fever
Night Sweats
Hot Flashes
Significant Weight Loss
Loss of Appetite
Significant Weight gain

2. ENDOCRINE GLANDS
Goiter
Excessive Thirst
Excessive Hunger
Underactive Thyroid
Overactive Thyroid

3. SKIN
Rash
Boils
Sores
Eczema
Moles
Have the moles changed color or size? Y/N

4. LYMPH NODES
Neck Swelling
Armpit Swelling
Groin Swelling
Glaucoma

5. EYES
Wear Glasses
Vision Changes
Eye Pain
Blurred Vision
Wear Contacts
Double Vision
Blind Vision
Drainage from Ears

6. EARS
Difficulty Hearing
Pain in Ears
Frequent Ear Infections

7. NOSE AND SINUSES
Frequent Nosebleeds
Sinus Congestion
Hay Fever

8. MOUTH AND THROAT
Sores in the Mouth
Hoarseness
Problems with Tonsils

9. LUNGS
Cough
Wheezing
Emphysema
Chest Discomfort
Rapid Heart Beat
Irregular Heart Beat

Previous Chest X-RAY
Positive TB Skin Test
Coughing Up Blood
Chronic Bronchitis
Heart Murmur
Palpitation(s)/ Heart Thump
Vein Problems in Legs
Shortness of Breath

10. HEART AND BLOOD VESSELS
Chest Pain
Wake Up Short of Breath
Sleep on 2 or More Pillows
Rheumatic Fever
Swelling in Ankles
Cramps in Legs
Get Winded Easily

11. ABDOMINAL ORGANS
Abdominal Pain
Heartburn/Indegestion
Vomiting Blood
Diarrhea
Hepatitis
Jaundice
Gallstones

Ulcers
Blood or Mucus in Stools
Rectal Pain
Bloating After Meals
Heavy Drinking
Frequest Use of Antacids
Problem Swallowing

Liver Disease
Constipation
Hemorrhoids
Black, Tarry Stools
Change in Bowel Habits

13a. GENITALS (MEN ONLY)
Sores on Penis
Prostate Trouble
Impotence
Discharge From Your Penis
Difficulty Voiding
Venereal Disease

12. KIDNEYS OR BLADDER
Difficult/Painful Urination
Very Frequent Urination
Kidney Disease
Protein in Urine
Can't Hold Urine

Frequent Night Urination
Blood in Urine
Frequent Infections
Kidney Stones
Sugar in Urine

13b. GENITALS (WOMEN ONLY)
Abnormal Pap Swear
Irregular Periods
Pain on Intercourse
Breast Lumps
Venereal Disease
Unusual Vaginal Discharge

Pelvic Pain
Problems with Sex
Abnormal Bleeding
Nipple Discharge

Please indicate the number of:
Pregnancies _____
Normal Deliveries _____
Premature Deliveries _____
Miscarriages _____
Abortions _____

14. MUSCLES, BONES AND JOINTS
Deformities
Pain in Joints
Swelling in Joints
Muscle Weakness
Chronic Pain in Back
Gout

13c. GENITALS (WOMEN ONLY)
Age when menstrual period began:_____
Date last period begain:_____
Living Children:_____
_____
Date of last pap smear:_____
Birth Control Method: _____
Do you know how to examine your breast? Yes or No

15. NERVOUS SYSTEM
Frequent/Severe Headaches
Head Injury
Seizures/Fits/Convulsions/Epilepsy
Weakness
Difficulty Sleeping
Severe Anxiety
Numbnesss or Tingling
Suicidal Thoughts
Desire Psychiatric Help
Feel Sad or Depressed

16. IMMUNIZATIONS
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:_____