SWEDISH
MEDICAL GROUP

ADULT PATIENT HISTORY

PATIENT LABEL HERE

Last name: _____ First name: _____ Date of Birth_____Sex: F / M

Allergies: _____

Medications (if you need more space for medications, please use the back of this form)

Name of Medication	Dosage	How many times per day	Date started	Prescribed by

Your Past Medical History (indicate the date of any significant medical problems)

Date	Medical Problem	Date	Medical Problem	Date	Medical Problem
	Alcohol/Drug Problem		Osteoporosis		Liver Problem
	Allergies/Hay Fever		Diabetes		Seizures
	Arthritis		Depression/Suicide Attempt		Sexually Transmitted Disease
	Asthma/Emphysema		Glaucoma		Stroke
	Bladder or Kidney Infections		Heart Disease/Heart Attack		Thyroid Condition
	Bleeding/Clotting		High Blood Pressure		Tuberculosis
	Cancer (Specify Below)		High Cholesterol		**Other:**
			Kidney Stones		

Past Surgical History (any surgery and Hospital stays you have had besides wisdom tooth extractions):

Date	Surgery/Hospital Stay	Date	Surgery/Hospital Stay

Family Medical History – Indicate family member. For extended family, note whether on mother's side or father's side.

Alcohol/Drug		Diabetes		Mental illness	
Allergies		Ear problem		Migraine	
Alzheimer		Endocrine		Nerve problem	
Anesthesia		Eye problem		Obesity	
Arthritis		Genetic		Psychiatric	
Asthma		Stomach/intestine		Lung problem	
Bipolar		Bladder/kidney		Schizophrenia	
Blood disease		Heart		Sickle cell	
Cancer		Blood pressure		Stroke	
Depression		Cholesterol		Thyroid	

Status of your family:

	Mother	Father	Sister(s)	Brother(s)	Children
Living: Indicate Birth year **or** current age					
Age at death					

Substance and Sexuality (please circle applicable ones)**:**

1. Tobacco use:
   - Never
   - Quit: packs/day:_____; years smoked:_____; quit date:_____; type of tobacco:_____.
   - Second-hand smoke
   - Current smoker: packs/day:_____; year started smoking:_____; type of tobacco:_____.
2. Alcohol use (each drink contains 0.5 oz alcohol):
   - No
   - Yes: Drink(s) per week:_____
3. Drug use:
   - No
   - Yes: number of use/week:_____ types:_____
4. Sexual Activity:
   - Yes: type of birth control:_____
   - No
   - Not currently
   - Partner preference: male / female

Activities and others:

- Blood transfusion: yes / no
- Caffeine (coffee, tea, soda): yes / no, if yes, how much per day: _____
- Diet: good / fair / bad / vegetarian / vegan
- Exercise: types:_____, _____min per day,_____times per week
- Do you wear seat belt in the car: yes / no
- Self-exam of breasts (for women), testes (for men) and skin: yes / no.

Home situation:

- Whom do you live with (Relationship): _____
- What is the name of your significant other: _____
- Names/ages of children: _____
- Do you feel safe at home: yes / no.

Education/occupation:

- Occupation:_____Employer: _____
- Years of education (high school grad = 12 years): _____
- What is your education degree: _____

Obstetrics (for women):

- How many times have you been pregnant:_____; age of first pregnancy: _____
- Number of full-term pregnancy (>37 weeks): _____; number of preterm pregnancy (<37 weeks): _____; number of miscarriage: _____; number of abortion: _____; number of ectopic pregnancy: _____; number of multiple births: _____; number of living children: _____.

Immunizations:

- Date of last tetanus shot (Td, Tdap): _____
- Date of last flu shot: _____
- Date of last pneumonia shot: _____
- Date of last MMR (measles, mumps, rubella): _____
- Dates of chicken pox vaccine (2 shots for adults) OR write “disease” if had the chicken pox disease: _____
- Date of Shingles Vaccine: _____

Health Care Maintenance (please <u>enter dates;</u> also write N for “normal” or AN “abnormal”):

Last pap smear (women): _____; Last mammogram (women): _____;
Last colonoscopy: _____; Last cholesterol: _____;
Last DEXA(bone density): _____; Last Fasting Blood Sugar _____