**SWEDISH** PHYSICIAN DIVISION

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

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|---|---|---|---|---|---|
| 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 enter dates; 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 _____