Cheryl Newman M.D.
Family Medicine

Adult History

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Name_____ Age:_____ D.O.B. ___/___/___

Most recent Primary Care Provider:_____

Health History

Please list all current medical problems:

Please list ALL of the medications you take on a regular basis:
(Please include prescription drugs, home remedies, over-the-counter medications, allergy or cold pills, laxatives, and vitamins. If you do not have enough room, please use another sheet of paper.)

Name Dose (mg or # of pills) How many times a day?

Are you allergic to any medications? _____ Reaction?_____

Are you allergic to anything else? _____

Please list all of the other doctors you see. Please include dentists, eye doctors, chiropractors, specialists, counselors, podiatrists, acupuncturists, etc.

Please list all surgeries, hospitalizations and procedures.

Reason	**Date (or age)**	**Doctor**	**Hospital**

Family History

Were you adopted? Y N

Parents:

Father: birth year _____ Medical problems:_____
Alive? Y N Cause of death: _____ Age (now or at death) _____
Mother: birth year _____ Medical problems:_____
Alive? Y N Cause of death:_____ Age (now or at death) _____

Siblings: None_____

Please list your **siblings**, along with their **birth year**, any **medical problems** (and if deceased, their age at that time)

Children: None_____

Please list your **children**, along with their **birth year**, any **medical problems** (and if deceased, their age at that time)

Grandparents:

Mother's Mother: birth year _____ Medical problems:_____
Alive? Y N Cause of death:_____ Age (now or at death) _____

Mother's Father: birth year _____ Medical problems:_____
Alive? Y N Cause of death:_____ Age (now or at death) _____

Father's Mother: birth year _____ Medical problems:_____
Alive? Y N Cause of death:_____ Age (now or at death) _____

Father's Father: birth year _____ Medical problems:_____
Alive? Y N Cause of death:_____ Age (now or at death) _____

Any close relatives with: [ ] Breast Cancer [ ] Colon Cancer [ ] Skin Cancer
[ ] Prostate Cancer [ ] Ovarian Cancer [ ] Heart Disease
[ ] Lung Cancer [ ] Diabetes [ ] Asthma or Emphysema
[ ] None of these

Do any other diseases run in the family?_____

Habits

Y N Have you ever used tobacco?
If Yes: Do you use tobacco now? Y N If not, quit date? _____
How long have/had you smoked for? _____
How much? _____ per day
Which type: [ ] Cigarettes? [ ] Cigars? [ ] Pipe? [ ] Chew? Other? _____
Y N Have you ever used street drugs?
Y N Are you currently using any street drugs?
Y N Have you ever felt the need to cut down on your drinking or drug use?
Y N Have you ever not been able to remember things that happened while you were drinking or using drugs?
Y N As a result of drinking or drug use, have things happened that you wish had not happened?
Y N In the last year have you drunk or used drugs more than you meant to?
Y N Have you ever injected (shot up) drugs?

How many alcoholic beverages do you consume weekly?
Beer_____/wk Wine_____/wk Liquor_____/wk

How much caffeine do you drink?
Coffee _____cups/day Tea ____cups/day Soft drinks _____/day

Are you: [ ] Overweight [ ] Underweight [ ] About Right

What do you do for exercise?_____

How many days a week? _____ For how many minutes a day? _____
Are you on a special diet?_____

Educational / Occupational History

Highest grade in school completed or degree: _____
Current occupation? _____ [ ] Student [ ] Retired
Employed by (now, or last if retired): _____
How long there? _____

Y N Have you ever had a job which involved exposure to
[ ] Hazardous Chemicals or [ ] Radiation?

Are you disabled? Y N If yes, by what?_____

Have you been in the Military? _____

Life / Situational History

Birth Place:_____

Where did you grow up:_____

What is your Religion: _____

Marital Status: [ ] Single [ ] Married [ ] Partnered [ ] Divorced
[ ]Widowed [ ] Separated

If ever married – how many times? _____

Are you sexually attracted to: [ ] Men [ ] Women [ ] Both

Please list *everyone* living in your household:

Name	**Relationship (if any)**	**Age**	**Occupation**

Have you been immunized against: [ ]Hepatitis B (3 shots) [ ] Pneumonia [ ] Influenza
[ ] Tetanus [ ] Zoster/Shingles [ ] HPV [ ] Meningitis

Date of Last Tetanus shot:_____

Do you drive? Y N

Do you use: [ ]Glasses [ ]Hearing Aide [ ]Cane/Walker [ ]Dentures [ ] None

Signature: _____ Date: _____