(addressograph stamp)

Stanford Hospital and Clinics
Stanford Family Medicine

ADULT HISTORY

Date Completed _____ Date of Birth _____

Note: Please complete all items, marking "no" or "none" for each section or item if it does NOT apply to you.

Have you ever had: Yes	No		For Health Center Use
☐	☐	Diabetes	
☐	☐	High blood pressure	
☐	☐	A heart murmur	
☐	☐	Heart trouble	
☐	☐	Heart attack	
☐	☐	High cholesterol	
☐	☐	Seizures	
☐	☐	Stroke	
☐	☐	Asthma	
☐	☐	Emphysema	
☐	☐	Hay fever/sinus	
☐	☐	Pneumonia	
☐	☐	Ulcers	
☐	☐	Hepatitis	
☐	☐	Thyroid problem	
☐	☐	Arthritis	
☐	☐	Anemia	
☐	☐	Venereal disease	
☐	☐	Urinary infection	
☐	☐	Cancer	
☐	☐	Breast lump	
☐	☐	Abnormal PAP smear	
☐	☐	Drug abuse	
☐	☐	Depression	
☐	☐	Psychotherapy	

OTHER MAJOR ILLNESSS OR INJURY (Conditions which lasted for more than a few days or which prevented work or usual activities for several days)

Year	What illness / injury

What is your blood type?

DRUG ALLERGIES OR SEVERE REACTIONS ☐ **NONE**

Drug	Year of Reaction	What happened?

DRUGS CURRENTLY TAKEN ☐ **NONE**

(Once/month or more)

Drug	How Often	What for?

STATEMENTS DESCRIBING YOUR USE OF MEDICATIONS: (Check one or more)

- ☐ Buy medication on my own to treat myself
- ☐ Never take medications unless prescribed
- ☐ Usually want a medication prescribed for my illness
- ☐ Willing to try non-drug treatments
- ☐ Strongly prefer non-drug treatments
- ☐ Never take drugs or only as last resort

SURGERY AND HOSPITALIZATIONS
(Do not include emergency room visits or childbirth)

Year	Why hospitalized / What surgery

Stanford Hospital and Clinics
Stanford Family Medicine

ADULT HISTORY

(addressograph stamp)

Date Completed _____

MENSTRUAL HISTORY

Age periods began _____

Spacing of periods _____

(No. of days from first day of one to first day of next)

Duration _____

(No. days of bleeding)

Amount of flow ÿ Light
ÿ Moderate
ÿ Heavy

Age periods stopped _____

SMOKING HISTORY

☐ Smoking cigarettes currently:
Packs/day _____
Year started _____

☐ Stopped smoking cigarettes
Year started _____
Year stopped _____
Pack day when smoked _____

☐ Smoke pipe or cigars currently
☐ Smoked pipe or cigars in past
☐ Never smoked

BIRTH CONTROL

(Check the statement which applies)

☐ Use birth control currently
Which method? _____
☐ Do not use birth control

ALCOHOL USE

☐ Do not drink alcohol currently
☐ Currently do drink (even occasionally)
How often: ☐ Less than 1 drink/month
☐ 1-3 drinks/month
☐ 1-3 drinks/week
☐ 1-3 drinks/day
How many drinks do you have at one time?
☐ 1 or 2 drinks
☐ 3 or 4 drinks
☐ 5 or more drinks
(One "drink" = one beer, one glass of wine, one shot of liquor or one mixed drink)

OBSTETRICAL HISTORY

Number of times pregnant _____
Number of full term babies _____
Number of premature babies _____
Number of abortions or miscarriages _____
Number of living children _____
Number of stillborn babies _____

HEALTH SCREENING AND PREVENTION

What was the year of your last:

Tetanus shot _____

Blood pressure measurement _____

Test of stool for blood _____

Sigmoidoscopy _____
(tube inserted into the rectum)

(Women)

Pap smear _____

Mammogram (x-rays of the breast) _____

Breast exam by medical practitioner _____

Cholesterol level:

☐ Never measured

☐ High (Year _____)

☐ Normal (Year _____)

Tuberculosis skin test:

☐ Never had one

☐ Negative test (Year _____)

☐ Positive test (Year _____)

HEALTH CENTER USE

dT					

(addressograph stamp)

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Stanford Family Medicine

ADULT HISTORY

Date Completed _____

Directions: For each of the following conditions, put an "X" in the appropriate box or boxes if any of your blood relations have had that condition or if you think they **may have had** that condition, but you are not sure.
NOTE: Please be sure to mark the "None in the family" column below if applicable.

	Not Applicable	Spouse	Father	Mother	Children	Brother(s)	Sister(s)	Father's Father	Father's Mother	Mother's Father	Mother's Mother	For Health Service Use
1. Diabetes												
2. High blood pressure												
3. Heart trouble												
4. Heart attack before age 35												
5. High cholesterol												
6. Stroke												
7. Glaucoma												
8. Breast cancer												
9. Asthma or hay fever												
10. Tuberculosis												
11. Kidney disease												
12. Mental retardation												
13. Mental illness												
14. Suicide												
15. Alcoholism												
16. Drug abuse												
17. Other cancer												
18. A genetic disease												
19. Other (specify)												
20												
21												
22												

	ALIVE				DEAD		
	Birthdate	(Check One) Well	Ill	Present Location	Year of Death	Age at Death	Cause
Father							
Mother							
Brother(s)							
Sister(s)							
Spouse							
Children							