STONECREEK
Family Physicians
4101 Anderson Avenue
Manhattan, KS 66503

Adult Medical History Form

	Today's Date:
Name (Last, Name MI):	**Date of Birth:**

Present Health Concerns:

Personal Medical History: Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis)

□ Blood Clots	□ Eye/Vision Problems	□ High Blood Pressure
□ Cancer Type_____ Date_____	□ Hearing Loss	□ Migraine Headaches
	□ Heart Problems □ Valvular (mitral/aortic) □ Rhythm (a-fib) □ Blockage (heart attack)	□ Stroke
		□ Thyroid Problems
□ Concussion		□ Other
□ Depression		
□ Diabetes	□ High Cholesterol	

Hospitalization History: (please list all prior hospitalizations and dates)

Hospitalization	Date	Hospitalization	Date

Surgical History: (please list all prior operations and dates)

Operation	Date	Operation	Date

Procedure History: (please list all prior procedures and dates, ie. Colonoscopy, bone density scan, heart cath, stress test)

Procedure	Date	Procedure	Date

Other Providers : (please list all prior providers you have seen and dates, ie. Orthopedics, Cardiologist, Dermatologist)

Provider	Date	Provider	Date

Women's Gynecologic History:

# of Pregnancies: ____# of Deliveries:___# of abortions:____# of miscarriages:____

Age at 1st period:	Frequency of periods:	Length of each:
Last Pap smear: _____Abnormal: □ yes □no		Last Mammogram:_____Abnormal: □ yes □no

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FAMILY HISTORY:

Relative	Year of Birth	Age of Death	Cause of Death	Health Issues (diabetes, high blood pressure, depression, cancer, etc)
Father				
Mother				
Siblings (please circle Brother or Sister)				
Brother / Sister				
Brother / Sister				
Brother / Sister				
Children (please circle Son or Daughter)				
Son / Daughter				
Son / Daughter				
Son / Daughter				
Other (please list relation to patient)				

Social History:

Occupation:	Marital Status (circle): Sgl / Mar / Wid / Div
Spouse/Partner's name:	Number of Children:
Who lives at home with you:	
Caffeine Intake: □ Never □ Occasional □ Daily	Alcohol: □ Never □ Occasional □ Daily □ Prior Use □ Quit Date _____ □ Amount per week: _____
Tobacco: □ Current - Type: _____ Freq: _____ □ 2nd Hand □ Never □ Prior Use □ Quit Date _____	Drug Abuse: □ Never □ Occasional □ Daily □ Prior Use □ Quit Date _____ □ History of drug abuse:_____

Medications: Prescription, non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Please attach additional sheet if necessary

Medication	Dose	Times per Day	Medication	Dose	Times per Day

Allergies or Reactions to Medicines/Foods/Other Agents: ☐ Check if no allergies

MEDICATION	Reaction or Side Effect

Immunizations: Please list your most recent immunizations and date received (your best estimate of the month/year it was given). You do NOT need to include any immunizations given at Stonecreek Family Physicians.

☐ Hepatitis A:	☐ Measles/Mumps/Rubella (MMR):	☐ Pneumovax (Pneumonia):	Other:
☐ Hepatitis B:	☐ Tetanus/Pertussis (Tdap):	☐ Prevnar 13:	☐ Gardasil (HPV):
☐ Shingles (Zostavax):	☐ Tetanus Td:	☐ Varicella (Chicken Pox):	☐ Meningitis: