Sheikh Medical Care PLLC

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ADULT HEALTH HISTORY

Name: _____ **Age:** _____

Date: _____ **Date of Birth:** _____ Male Female

How or who referred you to our office:

What is the reason for you visit today?

1. MEDICAL HISTORY (Past) — MAIN MARK CONDITIONS YOU HAVE OR HAD PREVIOUSLY

CONDITION	YEAR	CONDITION	YEAR	CONDITION	YEAR
Acid Reflux (GERD) ☐		Eczema ☐		Mumps ☐	
Alcoholism ☐		Gastritis ☐		Osteoarthritis ☐	
Alzheimers ☐		Glaucoma ☐		Osteoporosis ☐	
Anemia ☐		Goiter ☐		Pap Smear Abnormal ☐	
Anorexia ☐		Gonorrhea ☐		Parkinson's ☐	
Anxiety ☐		Gout ☐		Pneumonia ☐	
Arthritis ☐		Heart Attack (MI) ☐		Polio ☐	
Asthma ☐		Heart Murmur ☐		Prostate Cancer ☐	
Atrial Fibrillation ☐		Hemorrhoids ☐		Prostate Enlarged ☐	
Back Pain ☐		Hepatitis B ☐		Rheumatoid Arthritis ☐	
Bipolar ☐		Hepatitis C ☐		Rheumatic Fever ☐	
Bleeding Disorder ☐		Hernia (Hiatal) ☐		Seizures (Epilepsy) ☐	
Blood Clot Leg (DVT) ☐		Hernia (Inguinal) ☐		Shingles ☐	
Blood Clot Lung (PE) ☐		Herpes ☐		Sinusitis ☐	
Blood Transfusion ☐		High Blood Pressure ☐		Sleep Apnea ☐	
Breast Cancer ☐		High Cholesterol ☐		Stomach Ulcers (PUD) ☐	
Breast Lump ☐		HIV Positive ☐		Stroke ☐	
Bulimia ☐		Hypothyroid (low) ☐		Syphillis ☐	
Cataracts ☐		Hyperthyroid (high) ☐		TB Skin Test -positive ☐	
Celiac Disease ☐		Incontinence-urinary ☐		Tuberculosis ☐	
Chicken Pox ☐		Infertility ☐		Urinary infections recurrent ☐	
Cirrohsis ☐		Kidney Failure ☐		Vertigo ☐	
COPD/Emphysema ☐		Kidney Stones ☐		**Other Medical Conditions:** ☐	
Coronary Artery Disease ☐		Lung Cancer ☐		1. ☐	
Depression ☐		Lupus ☐		2. ☐	
Diabetes Type I (Child) ☐		Measles ☐		3. ☐	
Diabetes Type II (Adult) ☐		Melanoma ☐		4. ☐	
Diverticulitis ☐		Migraines ☐		5. ☐	

2. SURGERIES IN THE PAST — MARK SURGERIES YOU CURRENTLY HAVE OR HAVE HAD

SURGERY	YEAR	SURGERY	YEAR	SURGERY	YEAR
Angioplasty (PTCA) ☐		Colon Resection ☐		Knee Replaced ☐	
Aortic Valve Replaced ☐		Coronary Bypass ☐		Lumpectomy ☐	
Appendectomy ☐		Gallbladder (cholecystectomy) ☐		Mastectomy ☐	
Back Surgery-Discectomy ☐		Gastric Bypass ☐		Mitral Valve Replaced ☐	
Back Surgery-Fusion ☐		Hemorrhoidectomy ☐		Pacemaker ☐	
Bronchoscopy ☐		Hernia Repair ☐		Parathyroidectomy ☐	
C-Section ☐		Hip Replaced ☐		Rotator Cuff Repair ☐	
Carotid Endarterectomy ☐		Hysterectomy - Total ☐		Tonsillectomy ☐	
Carpal Tunnel ☐		Hysterectomy- Partial ☐		Tubal Ligation ☐	
Cartaract ☐		Knee Arthroscope ☐		Vasectomy ☐	

Physician Reviewed: _____ Date: _____

3. MEDICATIONS - LIST MEDICATIONS YOU CURRENTLY TAKE INCLUDE VITAMINS AND HERBS

Medications, Herbs, and Vitamins	Amount of Dose	Day/Times	Medications, Herbs, and Vitamins	Amount of Dose	Day/Times

4. ALLERGIES TO MEDICINES

Medication Name	List Reaction or Allergy Type

5. HEALTH MAINTENANCE

	Date
Bone density:	
Colonoscopy:	
Eye exam:	
Mammogram: (for women only)	
Pap smear: (for women only)	
Pneumonia vaccine:	

6. SOCIAL HISTORY

Work History:	Current / Former Occupation:
○ Currently working ○ Retired	

○ Single ○ Married ○ Divorced ○ Widowed

Do you **exercise** on a daily basis? ○ Yes ○ No

How many days or hours do you exercise every week?

Explain the type of exercise you do?

Do you drink **alcohol** on a regular basis? ○ Yes ○ No

How many drinks you take per week?

Do you use **tobacco** currently? ○ Yes ○ No

In which year you started smoking?

Cigarettes?	○ Yes	○ No	Packs / day
Cigars?	○ Yes	○ No	#/week
Passive smoke?	○ Yes	○ No	per day
Smokeless?	○ Yes	○ No	

Have you used tobacco ever in the past? ○ Yes ○ No

In which year you began smoking?

In which year you quit smoking?

Does **stress** often affect your health? ○ Yes ○ No

Do you or have you ever utilized **illicit drugs**? ○ Yes ○ No

Describe your current **diet?** (Tick all that apply)

☐ Regular & Healthy	☐ Low salt
☐ Regular & needs to improve	☐ Low carbohydrate
☐ Diabetic	☐ Gluten free
☐ Low cholesterol & fat	☐ Vegetarian

7. FAMILY HISTORY

Mark if your blood relatives have had any of these conditions

Condition	Relation to you
Alcoholism	☐
Alzheimers	☐
Anemia	☐
Anxiety	☐
Asthma	☐
Bleeding disorder	☐
Breast cancer	☐
Celiac disease	☐
Crohn's disease	☐
Colon cancer	☐
Depression	☐
Diabetes	☐
Heart attack	☐
Heart disease	☐
High blood pressure	☐
High cholesterol	☐
Kidney disease	☐
Lung cancer	☐
Lupus	☐
Melanoma	☐
Migraines	☐
Osteoporosis	☐
Prostate cancer	☐
Rheumatoid arthritis	☐
Stroke	☐
Seizures	☐
Thyroid disease	☐

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8. REVIEW OF SYSTEMS

Mark if you have or have had any of the below Problems or Concerns within the last few months:

GENERAL	CV (heart)	GU (urinary)	PSYCHIATRY
☐ Abnormal bleeding	☐ Chest discomfort	☐ Blood in urine	☐ Anxiety
☐ Abnormal bruising	☐ Chest pain	☐ Inability to control bladder	☐ Depression
☐ Chills	☐ Difficulty breathing @ night	☐ Inability to empty bladder	☐ Hallucinations
☐ Cold intolerance	☐ Exercise intolerance	☐ Frequent urination	☐ Suicidal thoughts
☐ Dizziness	☐ Leg cramps with exercise	☐ Genital sores	☐ Violent thoughts
☐ Fainting	☐ Palpitations	☐ Lack of sexual drive	**MEN ONLY**
☐ Fatigue	☐ Racing heart beats	☐ Night time urination	☐ Erection problems
☐ Fever	☐ Swelling	☐ Painful urination	☐ Lump in testicle
☐ Flushing	**RESP (lungs)**	☐ Urinary urgency	☐ Penis discharge
☐ Heat intolerance	☐ Breathing problems	☐ Weak urinary stream	☐ Sore on penis
☐ Loss of appetite	☐ Cough	**Muscles & Joints**	**WOMEN ONLY**
☐ Lymph node enlarge	☐ Coughing up blood	☐ Back pain	☐ Abnormal PAP
☐ Night sweats	☐ Joint pain	☐ Joint pain	☐ Breast lump
☐ Sleep disturbance	☐ Snoring	☐ Joint swelling	☐ Breast pain
☐ Thirst excessive	☐ Sputum	☐ Morning stiffness	☐ Heavy bleeding
☐ Weight gain	☐ Wheezing	☐ Muscle cramps	☐ Hot flashes
☐ Weight loss	**GI (gastrointestinal)**	☐ Muscle weakness	☐ Irregular periods
Eyes	☐ Abdominal pain	**SKIN**	☐ Nipple discharge
☐ Blurry vision	☐ Black tarry stools	☐ Change in moles	☐ Painful intercourse
☐ Double vision	☐ Bloating	☐ Excessive dry skin	☐ Painful periods
☐ Dry Eyes	☐ Bloody stools	☐ Hair loss	☐ Vaginal discharge
☐ Eye discharge	☐ Change in bowel habits	☐ Hives	☐ Vaginal itching
☐ Eye pain	☐ Constipation	☐ Itching	
☐ Floaters	☐ Diarrhea	☐ Nail changes	
☐ Light sensitivity	☐ Excessive gas	☐ Rash	
☐ Vision loss	☐ Heartburn & indigestion	☐ Skin cancer	
Throat, Nose, Ears	☐ Hemorrhoids	☐ Sores non-healing	
☐ Bleeding gums	☐ Nausea	**NEUROLOGY**	
☐ Earache	☐ Swallowing difficulty	☐ Concentration difficulty	
☐ Ear discharge	☐ Swallowing pain	☐ Falling down	
☐ Hearing loss	☐ Vomiting	☐ Headaches	
☐ Hoarseness	☐ Vomiting blood	☐ Numbness or tingling	
☐ Nasal congestion		☐ Paralysis	
☐ Nosebleeds		☐ Poor balance	
☐ Ringing in the ears		☐ Seizures	
☐ Seasonal allergies		☐ Tremors	
☐ Sore throat		☐ Weakness	
☐ Vertigo			

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