Stewart MEDICAL GROUP

Patient Name: _____

Date of Birth: _____

PATIENT INFORMATION:			
First Name:	Last Name:	M.I.	Date of Birth:
Street Address:	City:	State	Zip code:
*Check Primary Phone ☐ Home Phone	☐ Work phone	☐ Cell Phone	
Alternate name (if different from above):	Email address:		
Gender: ☐ Male ☐ Female	SSN:	Preferred Language:	Driver's License #:

Marital Status:	Preferred Contact:	Race:
☐ Single ☐ Married	☐ Mail	☐ American Indian ☐ Hispanic/Latino
☐ Widowed ☐ Life Partner	☐ Home Phone	☐ Asian ☐ White
☐ Divorced	☐ Work Phone	☐ Pacific Islander ☐ African American
☐ Separated	☐ Cell Phone	☐ Other:_____

Referred By:

Employment Status: ☐ Unemployed ☐ Full time ☐ Retired ☐ Student ○ Full time ○ Part time

Patient's Employer:	Patient's occupation:

Spouse's Employment Status: ☐ Unemployed ☐ Full time ☐ Retired ☐ Student ○ Full time ○ Part time

Spouse's Employer:	Spouse's occupation:

RESPONSIBLE PARTY: (GUARANTOR) ☐ SAME AS PATIENT		Relationship to patient:	
First Name:	Last Name:	M.I.	Date of Birth:
Street Address:	City:	State	Zip code:
*Check Primary Phone ☐ Home Phone	☐ Work phone	☐ Cell Phone	
Gender: ☐ Male ☐ Female	SSN:	Preferred Language:	Driver's License #:

EMERGENCY CONTACT (FOR MINOR, THIS SECTION MAY BE USED FOR OTHER PARENT)			
1. Name: (first, last)		Relationship to patient:	Date of Birth:
Street Address:		City:	State Zip code:
*Check Primary Phone ☐ Home Phone		☐ Work phone	☐ Cell Phone
2. Name: (first, last)		Relationship to patient:	Date of Birth:
Street Address:		City:	State Zip code:
*Check Primary Phone ☐ Home Phone		☐ Work phone	☐ Cell Phone

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Insurance information:		
1. Primary Insurance Carrier:	Primary Insurance Carrier Address:	Relationship to Policy Holder: ☐ self ☐ spouse ☐ parent
Primary Insurance Phone #	Policy and/or Subscriber ID #	Group #
2. Secondary Insurance Carrier:	Secondary Insurance Carrier Address:	Relationship to Policy Holder: ☐ self ☐ spouse ☐ parent
Secondary Insurance Phone #:	Policy and/or Subscriber ID #	Group #

Work or Auto Injury ☐ yes ☐ no	Do you have an attorney ☐ yes ☐ no	If yes, list attorney and/or W/C adjustor's name and phone #

ADVANCED DIRECTIVES

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐Living Will ☐HC Proxy

Date Reviewed:_____

Medical History – check all that apply, include year onset

Condition	Year	Condition	Year
☐ **None**		☐ Gallbladder Disease	
☐ Allergies. Type:_____		☐ GERD (reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina (Chest Pain)		☐ Hyperlipidemia (High Cholesterol)	
☐ Anxiety		☐ Hypertension (High Blood Pressure)	
☐ Arthritis (Rheumatoid or Osteoarthritis)		☐ Irritable Bowel Syndrome	
☐ Asthma		☐ Liver Disease	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Blood Clots		☐ Myocardial Infarction (Heart Attack)	
☐ Cancer – Type:_____		☐ Osteoporosis	
☐ Cerebrovascular Accident (Stroke)		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Prostate Enlarged (BPH)	
☐ COPD (Emphysema)		☐ Renal / Kidney Disease	
☐ Crohn's Disease		☐ Seizure Disorder	
☐ Depression		☐ Thyroid Disease	
☐ Diabetes		☐ Other: _____	

Health Maintenance – Check all that apply, include date of most recent exam

Exam	Date	Exam	Date
☐ **None**		☐ Eye Exam	
☐ Physical Exam		☐ DEXA/Bone Scan	
☐ Cardiac Stress Test		☐ Foot Exam	
☐ Echocardiogram		☐ Lipid Panel	
☐ EKG		☐ Influenza vaccine	
☐ Colonoscopy / Sigmoidoscopy		☐ Pneumococcal Vaccine	
☐ FOBT (stool card for hidden blood)		☐ Tetanus Vaccine	

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Surgical History			
Surgical Procedure	**Year**	**Surgical Procedure**	**Year**
☐ **None**		**Male Only**	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/ Stent		☐ TURP (Transurethral resection of prostate)	
☐ Appendectomy		☐ Vasectomy	
☐ Arthroscopy Knee		☐ Other:_____	
☐ Back Surgery			
☐ CABG (heart bypass)			
☐ Carpal Tunnel Release		**Female Only**	**Year**
☐ Cataract Extraction		☐ Augmentation Mammoplasty	
☐ Cholecystectomy (gallbladder)		☐ Bilateral Tubal Ligation	
☐ Colectomy		☐ Breast Biopsy	
☐ Colostomy		☐ Cesarean Section	
☐ Gastric Bypass		☐ D and C (dilatation & Curretage)	
☐ Hernia Repair		☐ Hysterectomy	
☐ Hip Replacement		☐ Mastectomy	
☐ Knee Replacement		☐ Myomectomy	
☐ LASIK eye surgery		☐ Reduction Mammoplasty	
☐ Liver Biopsy		☐ TAH/BSO	
☐ Pacemaker		☐ Vaginal Hysterectomy	
☐ Small Bowel Resection		☐ Other:_____	
☐ Thyroidectomy			
☐ Tonsillectomy		☐ Other surgery:_____	

Female only:

Past pregnancies: Total number of pregnancies:_____ Number of Births:_____ Number of Miscarriages:_____
Number of abortions:_____ Number of children alive:_____

Date of last menstrual period:_____ # of days between cycles:____ ☐ Regular ☐ Irregular ☐ Light ☐ Normal ☐Heavy

What kind of birth control do you use? ☐ none Type:_____

Date of Last Pap Smear:_____ Last Mammogram:_____ Last Breast Exam:_____

MEDICATIONS – List all medications you take, prescription and non-prescription

☐ **I do not take any medications**

Medication Name, Dosage, & Frequency	Medication Name, Dosage, & Frequency

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ **No Known Allergies**

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Family History – check if any family member(s) has had any of the following conditions

☐ **No Known Family Medical Conditions** ☐ Adopted

Diagnosis	Father	Mother	Brother	Sister	Other: List Family Member
Alcoholism	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐
CAD (Heart Disease / Heart Attack)	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐
CVA (stroke)	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Hearing Deficiency	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Peripheral Vascular Disease	☐	☐	☐	☐	☐
Renal / Kidney Disease	☐	☐	☐	☐	☐
Other: (specify)	☐	☐	☐	☐	☐

Social History For Adult Patient

Occupation: _____	Do you have Children? ☐ Yes ☐ No	How many Male(s)?	Female(s)?
Exercise Activity ☐ No	☐ Minimal ☐ Moderate ☐ Vigorous Days/Week:____ Type of Exercise:	Sleep patterns: ☐ changes ☐ no changes	
Sexually Active ☐ No	☐ With Men ☐ with women ☐ both ☐ One partner ☐ Multiple Partners	Type of Contraception: ☐ None ☐ Condoms ☐Oral Pills ☐ IUD ☐ Other:_____	
Tobacco Use ☐ No	**For Current Smokers:** How many per day?___ How many years?____ **For Ex-Smoker:** How many per day?___ How many years?___ ☐ Former/Year Quit:	☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chewing ☐ Smokeless	
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less # of drinks per day?_____ Per week?_____ ☐ Former/Year Quit:	☐ Beer ☐ Wine ☐ Liquor ☐ Other:_____	
Illicit Drug Use ☐ No	☐ Daily ☐ Weekly ☐ Less Last time usage:_____	☐ Marijuana ☐ Crystal Meth ☐ Speed ☐ Other:_____	
Caffeine Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit:	☐ Chocolate ☐ Coffee ☐ Tablets ☐ Soda ☐ Tea ☐ Other: _____	

Social History For Pediatric Patient

Patient lives with:	☐ Mother	☐ Father	☐ Both Parents	☐ Other:
Mother's Occupation:			Father's Occupation:	
Parents Relationship: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated			Childcare: ☐ Mother ☐ Grandparent ☐ Sibling ☐ Father ☐ Nanny ☐ Daycare	
Tobacco Exposure ☐Yes ☐No, Smokers at home ☐Yes ☐No			Patient is current smoker: ☐ Yes ☐ No	