# John A. Stewart, M.D.
# Medical History Questionnaire

Patient Name _____Chart# _____

Date of birth _____ Age _____ Sex _____ Height _____ Weight _____

Race_____ Hispanic/Latino? Yes or No Preferred Language_____

Pharmacy_____

Reason for seeing Doctor: _____

List any **Drug Allergies** _____ / **Latex Allergy**? Yes or No

List **current medications** _____

_____

**Past Medical History**

Do you have, or have you had, any of the following: (**PLEASE CIRCLE**)

Diabetes High blood pressure Heart condition Cancer Blood or bleeding disorder Arthritis Dermatitis

Hepatitis High Cholesterol HIV/AIDS Lupus Psoriasis Skin Cancer Thyroid Problems

List other medical conditions and/or illnesses not mentioned above

_____

_____

List reasons for hospitalizations and/or surgeries (**within the last year**) with dates and any complications

_____

_____

**Family History** : (**PLEASE CIRCLE**)

Skin Cancer Relationship_____ Arthritis Relationship_____

Other Cancer Relationship_____ Lupus Relationship_____

**Social History**

Marital status _____ Education (Years/Degrees) _____

Alcohol use (type/amount) _____Tobacco use (amount/years used)_____

Employer _____Occupation _____

**Review of Systems** (**Circle positive symptoms** and describe and/or add others, if needed.)

**Skin:** Rash, Itching, Dryness, Burning, Skin Lesions, Scars, Acne

**Cardiovascular:** Chest pain, murmur, palpitations, Pace Maker

**Blood:** Anemia, bleeding tendencies, bruising tendencies

**Psychiatric:** Depression, anxiety

**Other:**

_____

_____ _____ _____ _____

**Patient Signature** **Date** **Physician Signature** **Date**