

Patient History

Name _____ Date _____ Birthdate _____

I am a Male Female

Do you have an Advance Directive? Yes No Don't Know Want Information

Past Medical History: (please check all that apply)

Childhood Diseases: .. asthma chicken pox..... measles meningitis mumps..... rheumatic fever

Adult Illnesses: asthma bipolar disorder..... bronchitis cancer depression/anxiety
 diabetes .. eczema emphysema glaucoma.... heart attack/failure
 hepatitis .. high blood pressure.... high cholesterol.. HIV schizophrenia
 seizure stroke TB thyroid disease ulcer

Other _____

Operations

<u>Type</u>	<u>When</u>	<u>Where</u>
_____	_____	_____
_____	_____	_____

Hospitalizations: (other than the above operations)

<u>Type</u>	<u>When</u>	<u>Where</u>
_____	_____	_____
_____	_____	_____

Current Medications/Over-the-Counter/Vitamins/Herbs: (if you don't know the name, please indicate why you take them)

Allergies

Medications _____
Other (food, latex, environmental) _____

Health Maintenance Screening

Last Tetanus shot _____ Last Flu shot _____ Last Pneumonia shot _____
Last Mammogram _____ Colonoscopy/sigmoidoscopy _____ Stool test for blood _____
Last Cholesterol test _____ Exercise: How often _____ Type _____
Number of meals eaten per day _____ Number of dairy servings per day _____
Recent weight gain/loss _____
Do you need help with: dressing hygiene eating chores walking other _____?

Family History

Father: Living – age _____, health problems _____
 Deceased – age _____ and cause of death _____
Mother: Living – age _____, health problems _____
 Deceased – age _____ and cause of death _____
Brothers or Sisters: Living – age(s) _____, health problems _____
 Deceased – age(s) _____ and cause of death _____

General Family History: (check and write which family member in relationship to you)

- Diabetes _____
- Stroke _____
- High Blood Pressure _____
- High Cholesterol _____
- Heart Disease _____
- Cancer _____
- Mental Illness _____

Current Problems: (please check all that apply)

- Skin:*..... hives rashes
- Head:*..... fainting severe headaches
- Eye/Ear:*..... pain difficulty seeing/hearing
- Dental, lip or throat:* dentures difficulty swallowing
- Heart:*..... racing heart murmur severe chest pains
- Lung:*..... chronic cough difficulty breathing ... cough up phlegm/blood ... abnormal chest x-ray
- Breast:* lumps pain discharge
- Gastro-intestinal:* nausea constipation stomach pains/bloating ... vomited blood
 rectal bleeding loose/black stools
- Urinary:* bloody urine penis discharge problem with erection
 frequent/burning with urination difficulty starting/leaking urine
- Blood:* clotting abnormal bleeding
- Muscle, Bone, Joint:* pain swelling
- Mental Health:* nervousness problem sleeping hearing voices seeing things
 sadness thoughts of hurting myself or someone else .. drug or alcohol abuse

Other _____

- Sexual: Are you in a sexual relationship? Yes No Partner: Male Female
- How long with current partner(s)? _____
- How many sex partners have you had in your life? _____
- Bleeding/Pain after sexual relations? Yes No
- Are you satisfied with your sex life? Yes No

- Female Only First day of last period _____ Cramping before or with period _____
- Days between periods _____ Length of periods _____
- Pass clots with period? Yes No Last pelvic exam/Pap smear _____
- Method of birth control _____ How long on birth control _____
- Itching in vaginal area? Yes No Unpleasant odor? Yes No
- Any abnormal Pap smear results? Yes No
- Number of: Pregnancies _____ Births _____ Miscarriages _____ Abortions _____
- Do you do a self-breast exam monthly? Yes No

- Male Only Do you do a self-testicular exam monthly? Yes No
- If over 40 years of age, have you had a prostate test or exam done? Yes No

- Social History Married Separated Divorced Widowed Single

Occupation _____

Who do you live with? _____

Do you feel safe in your home? Yes No Are you afraid of anyone? _____

Is there a gun in your home? Yes No If so, is the gun locked when not in use? Yes No

Has anyone ever threatened/hit/pushed/abused you? _____

Have you ever been forced to have sex/do something sexual you didn't want to do? Yes No

Smoke - Yes No How much _____ How long _____

Drink - Yes No How much _____ How long _____

Marijuana/cocaine/other - Yes No How often _____ How long _____

Completed forms may be emailed to: receptionnoreply@gracehealthmi.org Please call 269-965-8866 if you have questions or need assistance.