MichiganHEALTH SPECIALISTS

ADULT MEDICAL HISTORY

DATE	/ /
DOB	/ /

LEGAL NAME OF PATIENT

LAST	FIRST	MIDDLE	SOCIAL SECURITY #

PLEASE LIST ALL MEDICAL PROBLEMS BOTH CURRENT AND PAST

PROBLEM	HOW LONG?	PROBLEM	HOW LONG?

LIST ALL MEDICATIONS, INCLUDING PRESCRIPTION, OVER THE COUNTER AND HERBAL

MEDICINE	DOSAGE	MEDICINE	DOSAGE

PLEASE LIST ALL ALLERGIES

ALLERGY	REACTION	ALLERGY	REACTION

PLEASE LIST ALL HOSPITALIZATIONS

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

PLEASE LIST ALL MEDICAL PROCEDURES, BOTH INPATIENT AND OUTPATIENT

OPERATION/PROCEDURE	DATE	OPERATION/PROCEDURE	DATE

HAVE YOU HAD ANY OF THE FOLLOWING?	WHEN (WHAT YEAR)? WHERE?
COLONOSCOPY/FOBT/SIGMOIDOSCOPY	
CT ABDOMEN/PELVIS	
FLU VACCINE	
PNEUMONIA VACCINE	
TETANUS SHOT	
CHICKENPOX/CHICKENPOX VACCINE	
SHINGLES/SHINGLES VACCINE	
HEPATITIS B VACCINE	
MAMMOGRAM (*WOMEN ONLY*)	
PAP SMEAR (*WOMEN ONLY*)	
RECTAL EXAM (*MEN ONLY*)	
PSA (*MEN ONLY*)	

FAMILY HISTORY: PLEASE CHECK ANY OF THE FOLLOWING ILLNESSES IF THEY ARE PRESENT IN YOUR IMMEDIATE FAMILY (MOTHER, FATHER, SISTERS, BROTHERS)

☐HEART ATTACK	☐HIGH BLOOD PRESSURE	☐BIRTH DEFECTS	☐SICKLE CELL ANEMIA
☐BYPASS SURGERY	☐ALLERGIES	☐ASTHMA	☐DIABETES
☐BREAST CANCER	☐HIGH CHOLESTEROL	☐COLON CANCER	☐ARTHRITIS
☐CANCER _____	☐SEIZURES	☐STROKE	☐KIDNEY DISEASE

SOCIAL HISTORY

LIVING SITUATION	HABITS	TYPE AND HOW MUCH?
WHO DO YOU LIVE WITH:	DO YOU NOW OR HAVE YOU EVER SMOKED TOBACCO?	
TYPE OF HOME:	DO YOU NOW OR HAVE YOU EVER USED ALCOHOL?	
TYPE OF DIET:	DO YOU NOW OR HAVE YOU EVER USED DRUGS?	

HAVE YOU EVER HAD ANY SEXUALLY TRANSMITTED DISEASES (STD'S, CHLAMYDIA, TRICHOMONAS, GENITAL HERPES, GENITAL WARTS, SYPHILIS, GONORRHEA)?	WHAT TYPE?

REVIEW OF SYSTEMS (MARK WITH AN “X” IF YOU HAVE ANY OF THE FOLLOWING:

	CHANGE IN WEIGHT		RASHES/ITCHING
	FEVER		LUMPS/MOLES
	FATIGUE		DIFFICULTY SWALLOWING
	NOT FEELING WELL		NAUSEA/VOMITING
	INCREASED OR DECREASED APPETITE		CONSTIPATION
	TROUBLE SLEEPING		ABDOMINAL PAIN
	SNORING		JAUNDICE (YELLOW EYES OR SKIN)
	FEELING TIRED AS COMPARED TO OTHERS		HEPATITIS
	FEELING COLD AS COMPARED TO OTHERS		VOMITING BLOOD
	CHANGE IN SKIN		BLOOD IN STOOL
	SKIN PROBLEMS		BLACK, TARRY STOOL
	CHANGE IN HAIR PATTERN OR AMOUNT		HEMORRHOIDS
	EATING TOO MUCH		HEARTBURN
	EXCESSIVE THIRST		PAIN DURING URINATION
	VISION PROBLEMS		WAKE UP TO URINATE
	RED EYE		FREQUENT URINATION
	DOUBLE VISION		BLOOD IN URINE
	EAR PAIN		DIFFICULTY STARTING A URINE STREAM
	EAR DRAINAGE		LEAKING OF URINE
	RINGING IN EARS		STONES
	RUNNY NOSE		
	NOSE BLEEDS		***MEN:***
	SORE THROAT OR TONGUE		TESTICULAR MASS OR PAIN
	HOARSENESS		PROBLEMS WITH ERECTION
	LUMPS OR SWELLING IN NECK		SEXUAL PROBLEMS
	CHEST PAIN		***WOMEN:***
	SHORTNESS OF BREATH		VAGINAL DISCHARGE OR INFECTIONS
	SHORTNESS OF BREATH LYING DOWN		PAINFUL PERIODS/HEAVY PERIODS
	SHORTNESS OF BREATH IN THE MIDDLE OF THE NIGHT		IRREGULAR/MISSED PERIODS
	SHORTNESS OF BREATH WITH EXERCISE		SEXUAL PROBLEMS
	FAINTING OR LIGHTHEADEDNESS		
	HEART FLUTTERING		PAIN OR STIFFNESS IN JOINTS
	TURNING BLUE		SWELLING OR REDNESS IN JOINTS
	LEG CRAMPS WITH EXERCISE		BACK PAIN
	WHEEZING		WEAKNESS OR CRAMPING
	COUGH		HEADACHES
	EDEMA (SWELLING OF THE ANKLES)		NUMBNESS/TINGLING
	ANXIETY/NERVOUSNESS		SEIZURES
	DEPRESSION		MEMORY PROBLEMS/CONFUSION

	PERSONALITY CHANGE/ MOOD SWINGS		UNSTEADY WHEN WALKING OR SITTING