MICHIGAN MEDICINE Family Medicine **Health History Questionnaire – Family Medicine – 11 Years of Age and Older**	MRN: NAME: BIRTHDATE: CSN:

Date of appointment _____/_____/__________ (mm/dd/yyyy)

Please fill this form out as completely as possible and bring this to your appointment.

If you have filled out this form previously, please enter any changes in your health history that have occurred since your last visit.

Past Medical History (Please check any medical problems that you have had in the past)

☐Abnormal pap smear
☐Alcoholism
☐Allergies
☐Anemia
☐Anxiety
☐Arthritis
☐Asthma
☐Blood transfusion
☐BPH (benign prostatic hyperplasia)
☐Cancer
☐Cataracts
☐Clotting disorder
☐Colonic adenoma
☐Concussion
☐Congestive heart failure
☐COPD (lung disease)
☐Coronary artery disease
☐Depression
☐Diabetes mellitus
☐Diverticulitis
☐GERD (heartburn)
☐Glaucoma
☐Headaches
☐Heart murmur
☐HIV/AIDS
☐Hyperlipidemia (high cholesterol)
☐Hypertension (high blood pressure)
☐Hypothyroidism
☐Irregular menses
☐Kidney disease
☐Liver disease
☐Menorrhagia
☐Myocardial infarction (heart attack)
☐Nerve/muscle disease
☐Osteoporosis
☐Seizures
☐Sickle cell anemia
☐Sleep apnea
☐Stroke
☐Substance abuse
☐Tuberculosis
☐Ulcers

☐Other (list)

____

Past Surgical History (Check any surgeries you have had and the date of surgery if you know it)

☐Appendectomy
☐Bariatric surgery
☐Brain surgery
☐Breast surgery
☐CABG (bypass)
☐Cesarean section
☐Cholecystectomy (gall bladder removal)
☐Colon surgery
☐Cosmetic surgery
☐Eye surgery
☐Fracture surgery
☐Hernia repair
☐Hysterectomy (ovaries removed)
☐Hysterectomy (ovaries remain)
☐Joint replacement
☐Other (list)
☐Prostate surgery
☐Small intestine surgery
☐Spine surgery
☐Tonsillectomy and Adenoidectomy
☐Tubal ligation (tubes tied)
☐Valve replacement
☐Vasectomy

Additional Information:

____

____

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Family History

Check below to report problems your family members have had. Please state the age when they had the problem if you know it. Please enter the name of the person in the blank.

☐Adopted (unknown/incomplete family history).

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Alcohol abuse							
Aneurysm							
Asthma							
Autoimmune disease							
Birth defects							
Breast cancer							
Cancer							
Colon cancer							
Colon polyps							
COPD (lung disease)							
Deep vein thrombosis							
Dementia							
Depression							
Diabetes							
Heart disease							
High cholesterol							
Hypertension							
Kidney disease							
Mental illness							
Osteoporosis							
Prostate cancer							
Pulmonary embolism							
Stroke							
Thyroid disease							
Other (list)							
Other (list)							
Other (list)							
Alive (Yes, No or N/A=Not Applicable)							

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For Female Patients Only:

Menstrual History

Age when period started _____ years ☐Period has not yet started. *Please skip to next section.*

Period cycle _____ days

Period duration _____ days

Period pattern: ☐Regular ☐Irregular

Menstrual flow: ☐Light ☐Moderate ☐Heavy

Menstrual control method:

☐Panty liner ☐Thin pad ☐Maxi pad ☐Hospital pad ☐Tampon ☐Other (specify) _________________

How often do you change your menstrual control method? Every _____ hours.

Dysmenorrhea (painful menstruation): ☐None ☐Mild ☐Moderate ☐Severe

Dysmenorrhea symptoms (please describe): ____

Age when menopause started _____ years

Date of last pap smear ________ History of abnormal pap smears? ☐No ☐Yes If yes, what was the abnormality (if known)? ____

If over age 40, date of last mammogram (approximate) __________

Pregnancy History:

☐ Never pregnant ☐ History of pregnancy ☐ Currently pregnant

Number of pregnancies (G) _____

Number of deliveries (P) _______ Number of preterm deliveries (<37 weeks) ______ Full term deliveries _______

Multiple birth deliveries________ Miscarriages/abortions__________ Living children __________

Comments (pregnancy complications): ____

Social History

Substance and Sexual Activity

Alcohol

Do you ever drink alcohol? ☐Yes – if yes, complete all alcohol related questions

☐No – if no, skip to next section

Please indicate the quantity per week of each:

Glasses of wine: ___________ Can/bottles of beer: ____________

Shots of liquor: ____________ Drinks containing .5 oz of alcohol: ____________

Have people ever felt like you should cut down on drinking? ☐Yes ☐No

Have people annoyed you by criticizing your drinking? ☐Yes ☐No

Have you ever felt guilty about your drinking? ☐Yes ☐No

Have you ever had an “eye-opener” (an alcoholic drink first thing in the morning) to help you feel better? ☐Yes ☐No

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Drugs and tobacco

Do you use drugs? ☐Yes ☐No

If you use drugs, how many times per week? _________

What type(s) of drugs do you use? __________________

Check one of the following about smoking tobacco:

☐Never smoked ☐Exposed to second hand smoke

☐Former smoker ☐Smoke some days ☐Smoke everyday

If you smoked or used to smoke, how many packs do or did you smoke per day? _________________

How many years did you smoke / have you smoked? _________________

If you quit smoking, when did you quit? ________________

Check one of the following about smoke<u>less</u> tobacco:

☐Never used ☐Former user ☐Current user

If you quit smokeless tobacco, when did you quit? __________________

Are you ready to quit smoking or using smokeless tobacco? ___________________

Do you use e-cigarettes?

☐No ☐Used in the past ☐Not presently ☐Occasionally ☐Daily

Sexual activity

Are you sexually active? ☐Yes ☐No ☐Not currently

If yes, are your partner(s): ☐Male ☐Female ☐Both

Type of birth control / protection (check all that you use):

☐Not having sex (abstinence) ☐Condom ☐Injection ☐IUD (intrauterine device)
☐Oral contraceptives (Pill) ☐Partner vasectomy ☐Patch ☐Post-Menopausal
☐Vasectomy ☐None ☐Other (specify):

Do you have a new sexual partner? __________

Lifestyle

On average, how many days per week do you engage in moderate to strenuous exercise?

☐1 day ☐2 days ☐3 days ☐4 days ☐5 days ☐6 days ☐7 days

On average, how many minutes do you engage in exercise at this level?

☐0 min ☐10 min ☐20 min ☐30 min ☐40 min ☐50 min ☐60 min ☐70 min

☐80 min ☐90 min ☐100 min ☐110 min ☐120 min ☐130 min ☐140 min ☐150+ min

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Safety

Do you have a gun at home? ☐Yes ☐No

Socioeconomic

Employment

Occupation: ____

Employer: ____

Demographics

Marital status: ☐Divorced ☐Legally separated ☐Married ☐Significant other
☐Single ☐Widow ☐Unknown ☐Other (specify): ________________________

Spouse name: ____________________________________

Number of children: ________________________________

Years of education: _________________________________

Review of Systems • *Please circle which symptoms you have currently.*

General	fever decreased/no energy loss appetite unintended weight gain/loss	none
Head	headache injury	none
Eye	visual change crossed discharge redness puffiness	none
Ear	difficulty with hearing pain discharge	none
Nose	runny nose nasal congestion nose bleed	none
Mouth/throat	sore throat difficulty swallowing dental problems	none
Lung	shortness of breath coughing chest pain wheezing sputum blood in sputum	none
Heart	pale cyanosis chest pain leg swelling faint	none
Gastrointestinal	abdominal pain nausea vomiting diarrhea constipation distention blood in stool black/tarry stool	none
Genitourinary	painful urination urine retention incontinence difficulty urinating blood in urine	none
Musculoskeletal	deformities joint pain joint swelling difficulty in moving	none
Neurologic	dizziness weakness hand shakiness seizures	none
Skin	rash itching color change easy bruising/bleeding change in mole	none
Psychiatric	frequent mood change nervousness tension feeling down unable to sleep at night	none

____ _____/_____/__________ (mm/dd/yyyy)

Printed name of person who completed this form Date

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