

**Midwest Family Medicine**

12640 E. 12 Mile Road

Warren, MI 48093

(586) 751-2020

**PATIENT HISTORY**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_

Requesting Physician \_\_\_\_\_

Primary Family Physician \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Occupation \_\_\_\_\_ Retired  Yes  No

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer's Address \_\_\_\_\_

Are you presently working?  Yes  No

If not, please provide last day you worked full time \_\_\_\_\_

**SPOUSE'S INFORMATION**

Spouse's Name (*if married*) \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer's Address \_\_\_\_\_



**ALLERGIES** Please list allergies to all medication, foods, dyes or materials.

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**REVIEW OF SYSTEMS** Are you currently experiencing any of the following?

<b>Constitutional</b>	Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>GUI</b>	Urinary Urgency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Weight Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Weight Gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Sexual Difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Eyes</b>	Blurred Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Muscular/ Skeletal</b>	Joint Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Wear Glasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Neck Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>ENT</b>	Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Skin</b>	Rashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sinusitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Neck Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Keloids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>CVS</b>	Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Neurological</b>	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Palpitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>GI</b>	Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Fecal Incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Where? _____		
					Numbness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
					Where? _____		
<b>Respiratory</b>	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Psychiatric</b>	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Other Psychiatric illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Coughing	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Blood Disorder</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
				(easy bruising, thin blood)			

Are you  Right handed  Left handed

## SOCIAL HISTORY

**Marital Status**     Single     Married     Divorced     Widowed

**Do you have any children?**     Yes     No    If so, how many \_\_\_\_\_

**Do you smoke?**     Yes     No    If so, \_\_\_\_\_ packs per day    how long \_\_\_\_\_

**Do you drink?**     Yes     No    If so, how many drinks per day \_\_\_\_\_

**Do you use drugs?**     Yes     No    If yes, please indicate type and how often \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FAMILY HEALTH HISTORY

**High Blood Pressure**     Yes     No

**Stroke**     Yes     No

**Diabetes**     Yes     No

**Heart Disease**     Yes     No

**Heart Attack**     Yes     No

**Cancer**     Yes     No

**Seizures**     Yes     No

**Psychiatric/Emotional Problems**     Yes     No

Relationship	IF LIVING		IF DECEASED	
	Age	Health Problems	Age at Death	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____
Aunt / Uncle	_____	_____	_____	_____
Aunt / Uncle	_____	_____	_____	_____
Sister / Brother	_____	_____	_____	_____
Sister / Brother	_____	_____	_____	_____
Children	_____	_____	_____	_____

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_