Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient's Medical History

Age 13 and Older

Please answer every question.

STAFF: Responses outlined in rectangle and handwritten items must be entered MANUALLY.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

The information in this form is used to populate the patient's Electronic Health Record and is necessary for MidMichigan Health to provide you with the best patient care possible. If there is information you are not comfortable completing, you may discuss this with the clinical staff in the privacy of the exam room.

PATIENT'S MEDICAL HISTORY

Please mark all items that apply:

PAST	CURRENT		PAST	CURRENT	
○	○	Alcohol Abuse	○	○	Hepatitis B
○	○	Anemia	○	○	Hepatitis C
○	○	Anesthetic Complication	○	○	High Blood Pressure
○	○	Anxiety Disorder	○	○	High Cholesterol
○	○	Arthritis	○	○	HIV
○	○	Asthma	○		Hives
○	○	Atrial Fibrillation	○		Joint Replacement
○	○	Back Pain	○	○	Kidney Disease
○		Blood Clot – Arm or Leg (DVT)	○	○	Liver Disease
○		Blood Clot – In Lung (PE)	○	○	Mental Illness
○		Blood Transfusion(s)	○	○	Migraines
○	○	COPD / Emphysema	○	○	Osteoporosis
○	○	Depression	○	○	Reflux / GERD
	○	Diabetes Type 1	○	○	Seizures / Convulsions
	○	Diabetes Type 2	○		Severe Allergic Reaction / Anaphylaxis
○	○	Growth / Development Disorder	○		Sexually Transmitted Disease (STD)
○		Heart Attack	○	○	Stomach / Gastric Ulcer
○	○	Heart Disease	○		Stroke
○	○	Heart Murmur	○		Suicide Attempt
○		Heart Pain / Angina	○	○	Thyroid Disorder
○	○	Hepatitis A	○	○	UTI (Urinary Tract Infection)

○ **NONE OF THE ABOVE**

CANCER HISTORY

Please mark all items that apply:

PAST	CURRENT		PAST	CURRENT	
	○	**NO CANCER**	○	○	Melanoma
○	○	Bladder Cancer	○	○	Non-Hodgkin's Lymphoma
○	○	Breast Cancer	○	○	Pancreatic Cancer
○	○	Cervical Cancer	○	○	Prostate Cancer
○	○	Colon Cancer	○	○	Rectal Cancer
○	○	Kidney Cancer	○	○	Skin Cancer
○	○	Leukemia	○	○	Thyroid Cancer
○	○	Liver Cancer	○	○	Uterine Cancer
○	○	Lung Cancer	○	○	Other Cancer

SURGICAL HISTORY

Please mark all surgeries that you have had:

○ **I HAVE HAD NO SURGERIES**

○ Adenoids Removed	○ Heart Bypass Surgery	○ Joint Replacement
○ Appendix Removed	○ Heart Stent	○ Mastectomy
○ Back Surgery	○ Heart Transplant	○ Pacemaker
○ Cardiac Ablation	○ Heart Valve Replacement	○ Prostate Surgery
○ Carotid Artery (Neck) Surgery	○ Hernia Repair	○ Tonsils Removed
○ Defibrillator	○ Hysterectomy	○ Varicose Vein Surgery

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Age 13 and Older
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FAMILY MEDICAL HISTORY

◯ **Family History UNKNOWN** ◯ **ADOPTED**

Please indicate which family member(s) have had these illnesses:	Father	Mother	Brother	Sister	Other Relative
Alcohol Abuse	◯	◯	◯	◯	◯
Arthritis	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯
Breast Cancer	◯	◯	◯	◯	◯
Colon Cancer	◯	◯	◯	◯	◯
Depression	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯
High Cholesterol	◯	◯	◯	◯	◯
Kidney Disease	◯	◯	◯	◯	◯
Mental Illness	◯	◯	◯	◯	◯
Migraines	◯	◯	◯	◯	◯
Seizures	◯	◯	◯	◯	◯
Stroke	◯	◯	◯	◯	◯
Suicide Attempt	◯	◯	◯	◯	◯
Thyroid Disorder	◯	◯	◯	◯	◯
Other Cancer	◯	◯	◯	◯	◯
NONE	◯	◯	◯	◯	◯

SOCIAL HISTORY

TOBACCO USE ◯ current (every day) ◯ previous
What is your smoking status? ◯ current (some days) ◯ never
Does anyone in your household smoke? ◯ yes ◯ no

ALCOHOL USE
Do you consume alcohol? ◯ daily ◯ occasionally ◯ never

STREET DRUG USE ◯ yes ◯ previous ◯ never

HABITS
How often do you drink caffeinated products? ◯ frequently ◯ occasionally ◯ never
Do you use sunscreen? ◯ always ◯ occasionally ◯ never

DOMESTIC VIOLENCE

The following questions provide valuable information to assist us with treating your overall personal health. You may discuss these matters with your provider if you would prefer.

Have you ever been hit, slapped, kicked or hurt by someone this year? ◯ yes ◯ no
Are you afraid of your partner or anyone else close to you? ◯ yes ◯ no
Do you have a history of emotional, physical or sexual abuse? ◯ yes ◯ no

ADDITIONAL INFORMATION

Have you ever had suicidal thoughts or attempted suicide? ◯ yes ◯ no
How do you prefer to learn? ◯ written material ◯ video / tv ◯ discussion / verbal
Do you have difficulty: ◯ seeing ◯ reading ◯ hearing
Have you fallen one or more times in the last 12 months? ◯ yes ◯ no
HIV high risk behavior? (HIV Risk Factors: IV drug use; more than one sexual partner; sex with a prostitute; unprotected sexual contact; contact with contaminated injection equipment.) ◯ yes ◯ no