Macomb Physicians Group PLLC

NAME _____ **DOCTOR** _____

Please check ("X") if you have had any of the following symptoms or conditions within the past year: _____
DATE

1. HEAD AND NECK
- ____ Frequent headaches
- ____ Migraine
- ____ Injury
- ____ Neck pains
- ____ Neck lumps

2. EYES
- ____ Recent change in vision

3. EARS
- ____ Hearing difficulty
- ____ Ringing / buzzing
- ____ Earaches
- ____ Discharge from ears
- ____ Motion sickness

4. NOSE AND THROAT
(x only if frequent)
- ____ Congested nose
- ____ Runny nose
- ____ Nose bleeds
- ____ Sore throat
- ____ Tonsillitis
- ____ Hoarse voice

5. MOUTH
- ____ Sores
- ____ Soreness
- ____ Dental problems
- ____ Changes in taste

6. RESPIRATORY
- ____ Short of breath
- ____ Wheezing
- ____ Chronic cough
- ____ Cough up phlegm
- ____ Cough up blood
- ____ Frequent chest colds
- ____ Pain on deep breath

7. CARDIOVASCULAR
- ____ Irregular heartbeat
- ____ Racing heart
- ____ Chest pain
- ____ Short of breath lying down
- ____ Swollen feet or ankles
- ____ Leg cramps
- ____ Cold hands / feet

8. GASTROINTESTINAL
- ____ Appetite loss
- ____ Trouble swallowing
- ____ Nausea / vomiting
- ____ Vomit blood
- ____ Heartburn
- ____ Recent change in bowel habits
- ____ Abdominal pain
- ____ Excess "belching"
- ____ Black stools
- ____ Rectal pain
- ____ Rectal bleeding
- ____ Bloating

9. URINARY
- ____ Frequent urination
- ____ Urgency
- ____ Burning on urination
- ____ Brown / Black / bloody urine
- ____ Passage of stones
- ____ Dribbling
- ____ Bedwetting

10. GENITAL
A. FEMALE
- ____ Lumps in breast
- ____ Abnormal PAP smear
- ____ Menstrual trouble
- ____ Post-menopausal bleeding
- ____ Vaginal discharge
- ____ No. of pregnancies
- ____ No. of premature births
- ____ No. of stillbirths
- ____ No. of miscarriages or abortions
- ____ Caesareans
- ____ No. of live children
- ____ IUD
- ____ Birth control pill
- ____ Other contraception
- ____ Hormones-menopause

B. MALE
- ____ Prostate trouble
- ____ Burning / discharge
- ____ Painful testicles
- ____ Weak urine stream
- ____ Abnormal lumps in scrotum

11. MUSCULOSKELETAL
- ____ Fractures
- ____ Aching muscles / joints
- ____ Muscle weakness
- ____ Handicapped
- ____ Swollen joints

12. SKIN
- ____ Itching
- ____ Scaling
- ____ Rashes
- ____ Bruises or bleed easliy
- ____ Change in moles

13. ENDOCRINE
- ____ Weight change
- ____ Always hungry
- ____ Impotence
- ____ Sterility
- ____ Tendency to feel hot
- ____ Tendency to feel cold
- ____ Dryness of skin / hair
- ____ Drink a lot of fluids
- ____ Change in skin pigmentation
- ____ Change in size of shoe / hat gloves since adult

14. NERVOUS SYSTEM
- ____ Trouble smelling
- ____ Weakness
- ____ Shaking
- ____ Speech difficulty
- ____ Convulsion
- ____ Faintness
- ____ Change in handwriting

15. MOOD
- ____ Nervous with strangers
- ____ Trouble with decisions
- ____ Trouble with memory
- ____ Trouble sleeping
- ____ Trouble relaxing
- ____ Depression
- ____ Shy
- ____ Strange dreams / thoughts
- ____ Worry a lot
- ____ Lose temper
- ____ Work / family problems
- ____ Sexual difficulty
- ____ Considered suicide
- ____ Desire psychiatric help

16. HABITS (How much per day)
- ____ Smoking _____
- ____ Alchohol _____
- ____ Coffee _____
- ____ Marijuana, Heroin, similar drugs

What specific questions do you have regarding your health? _____

HEALTH HISTORY

(Please print) DATE: _____

NAME: _____ BIRTHDATE: _____

MARITAL STATUS: _____ PHONE NUMBER: _____ (Home) _____ (Work)

PROFESSION: Occupation _____ Employer _____

Serious Illnesses which you have had (give dates) or have now: (not requiring hospitalization)

_____

_____

_____

_____

Write in the name and year of any operations which you have had or serious illnesses which required hospitalization:

_____

_____

_____

_____

FAMILY HISTORY

		Age	Health Problems
Father			
Mother			
Other (circle sex)	M F		

(X) is appropriate, record most recent date if possible).

Tests Yes	Year		Tests Yes	Year	
___	___	Chest X-Ray	___	___	Tetanus
___	___	Kidney X-Ray	___	___	Polio
___	___	Electrocardiogram	___	___	Diptheria
___	___	Stomach X-Rays	___	___	Measles
___	___	Gallbladder X-Ray	___	___	Mumps
___	___	Other X-Rays	___	___	Gammaglobulin
___	___	T.B. Test	___	___	Pneumovax
___	___	Diabetes Test	___	___	Hepatitis B
___	___	Thyroid Test	___	___	Others
___	___	Biopsies	___	___	_____
___	___	Proctoscopy	___	___	_____
___	___	_____			

MEDICATIONS
WHAT DRUGS ARE YOU NOW USING?
(Include vitamins, laxatives, aspirin, birth control pills.

_____

_____

_____

_____

WHAT DRUGS ARE YOU ALLERGIC TO?
WHAT KIND OF REACTION DID YOU HAVE?

_____

_____

_____

_____

Notes: