Macomb Physicians Group, PLLC.

Health History

Name:_____ **Age:**_____ **Today's Date:** ____ / ____ / 20____

Marital status: ☐ Single, ☐ Married, ☐ Separated, ☐ Divorced, ☐ Widowed.

Check all items either yes or no	NO	Yes New	Yes Old	Date	Check all items either yes or no	NO	Yes New	Yes Old	Date
Anemia					*Arthritis*				
Angina					*Asthma / Hay Fever*				
Heart attacks / By pass					*Blood Diseases*				
Diabetes					*Cataracts*				
High Blood Pressure					*Bronchitis / Emphysema*				
Elevated Cholesterol					*Liver Disease / Cirrhosis*				
Strokes / Mini strokes					*Colitis*				
Blocked Arteries in Leg or Neck					*Diverticulosis*				
Thyroid disease					*Gall Stones*				
Blood clots in legs / Lungs					*Stomach Ulcers / Reflux disease*				
Migraine Headaches					*Kidney Stones*				
Recurrent Sore Throat / Sinusitis					*Skin diseases / Psoriasis / Eczema*				
Heart Valve problems					*Blood in Stool or Urine*				
Hepatitis					*Night Sweats*				
Glaucoma					*Memory Loss*				
Epilepsy / Seizures					*Leg pain during walking*				
Alcohol / Drug abuse treatment					*Chest pain*				
Broken Bones / Joint Surgery					*Shortness of Breath*				
Cancer - Site:					*Weight loss / Weight Gain*				

Habits History

Habits	Yes	No	Amount		Habits	Yes	No	Amount
Smoke			_____ Packs / Day		Liquor			_____ Oz / Day
Coffee			_____ Cups / Day		Marijuana			_____ Joints / Week
Beer			_____ Cans / Day		Drugs			Name: _____

Family History

Check condition and relationship of the relative	Yes	No	Father	Mother	Brother	Sister	Son	Daughter	Check condition and relationship of the relative	Yes	No	Father	Mother	Brother	Sister	Son	Daughter
Diabetes									Mental illness								
Hypertension									Alcoholism								
Stroke									Obesity								
Heart attack age below 55																	
Emphysema																	
Colon Cancer																	
Breast Cancer																	

Medication and Allergy History

Medications (Long term only)	Dose	Allergy to medication	Type of reaction (Rash, Itching, Choking, Passed Out)
		No Allergy	
		Penicillin	
		Sulfa	
		See List	

I acknowledge that above information is correct to the best of my knowledge. I will not hold Macomb Physicians Group, PLLC or members of its staff responsible for any errors or omissions that I may have made in completion of this form.

_____ _____

Signature of the Person or Guardian Date Signed