# 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:**