Midwest Family Practice
12640 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 _____

_____

PAST MEDICAL HISTORY

High Blood Pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Blood Disorder (*Thin Blood*)	☐ Yes	☐ No

Please list all illnesses / medical conditions / hospital admissions below

_____

_____

_____

_____

Please list all past surgeries in chronologic order

Name of Surgery	Name of Surgeon / Hospital	Date of Surgery

MEDICATIONS

Please list all the medications you are currently taking including vitamins, nutritional supplements, herbal remedies and over the counter medications.

Name of Medication	Dosage or Strength	How Often Each Day

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

_____

_____

_____

_____

_____

_____

_____

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

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

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	**Heart Attack**	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	**Cancer**	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	**Seizures**	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	**Psychiatric/Emotional Problems**	☐ Yes	☐ No

	IF LIVING		*IF DECEASED*	
Relationship	*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 _____