Northern Michigan
Medicine and Pediatrics

ADULT MEDICAL HISTORY (Initial)

Patient Name	Today's Date
Maiden/Other Name(s)	Date of Birth

GENERAL *(enter month and year of most recent below)*			
Physical	Lipid Profile	Colonoscopy	
Men →	Prostate Exam	Prostate Blood Test	
Women →	PAP	Breast Exam	Mammogram	Bone Density

VACCINATION			
Flu	Tetanus	Shingles	Pneumonia

OTHER PROVIDERS List other practioners you see or other health encounters within the past 3 years including counseling, hospitalization, eye exam, gynecology, endocrinology, cardiology, dermatology, physical therapy, etc.:

MEDICATION *(use additional paper if needed)*

Pharmacy (local and/or mail order)	Prescription Coverage Carrier & ID#

Medication Name	Dose	Directions	Prescriber

MEDICATION ALLERGIES (include type of reaction):

MEDICAL HISTORY (check all that apply to you)	☐ Allergies, ☐ Anemia, ☐ Angina, ☐ Arthritis, ☐ Asthma, ☐ Atrial Fib, ☐ Blood Clots, ☐ C-Section, ☐ Cancer:____, ☐ COPD, ☐ Crohn's Disease, ☐ Depression, ☐ Diabetes Type_____, ☐ Gallbladder, ☐ GERD (reflux), ☐ Heart Attack, ☐ Hepatitis C, ☐ High Cholesterol, ☐ Hypertension, ☐ Irritable Bowel, ☐ Kidney Disease, ☐ Liver Disease, ☐ Migraines, ☐ Miscarriage, ☐ Osteoarthritis, ☐ Osteoporosis, ☐ Prostate Enlarged, ☐ PTSD, ☐ Seizure, ☐ Stroke, ☐ Substance Abuse, ☐ Trauma (physical), ☐ Trauma (sexual), ☐ Ulcer, ☐ Other:

Complete Back Side →

SURGICAL HISTORY		
Type	Date	Surgeon (if known)

FAMILY HISTORY	Age if Living	Age at Death	Heart Disease	High BP	Diabetes	Mental Illness	Cancer (include type)	Other Condition
Father								
Paternal Grandfather								
Paternal Grandmother								
Mother								
Maternal Grandfather								
Maternal Grandmother								
Brother(s)								
Sister(s)								

LIFE STYLE	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced
# of Children ____Biological ____Adopted ____Step	Military Service ☐ Yes ☐ No
Education ☐ Some High School ☐ High School Graduate ☐ Some College ☐ Technical Trade ☐ Degree	
Occupation ☐ Full Time ☐ Part Time ☐ Retired	
How active are you? ☐ Vigorous ☐ Mild/Occasional ☐ Sedentary	
Do you use nicotine products? ☐ Yes ☐ No If yes, type/frequency:	
Do you consume alcohol? ☐ Yes ☐ No If yes, frequency: ____Daily ____Weekly ____Monthly	

MENTAL HEALTH	**Not at all**	Several days	More than half the days	Almost everyday
Over the **<u>Last 2 Weeks</u>**, how often have you been bothered by any of the following?				
1. Loss of interest or pleasure in doing things				
2. Feeling down, sad, depressed				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself, failure, letting yourself or your family down				
7. Trouble concentrating including reading the newspaper or watching TV				
8. Moving or speaking so slowly, fidgety or restless				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

Are there any **Community Resources** you would like information about, such as support groups, in-home help, transportation assistance, advance care planning, assistance with utilities?	☐ Yes ☐ No ☐ Not Sure, Let's Talk About It Please list types of resources you are interested in learning about below: