Your legal name: _____
The name you use, if different from your legal name: _____
Date of birth: _____
Phone number: _____

Michigan State University
Adult New Patient Forms

Welcome to Michigan State University HealthTeam. Please take a few minutes to fill out the following health questionnaire. Please complete it to the best of your ability. If there are questions that you don't understand, please ask our medical staff at your visit. If there are questions you do not wish to answer, you may leave these blank.

What are the main health concerns you have that you would like to discuss today?
1)_____
2)_____
3)_____

What are your medical care goals?
1)_____
2)_____
3)_____

Medical History

Please check any medical conditions you currently have or have had in the past:

✓	Condition	Comments (age of onset, description, current level of control)
	ADHD	
	Acid reflux (GERD)	
	Addiction to alcohol or drugs	
	Allergies (environmental/seasonal)	
	Anemia (low blood count)	
	Anxiety	
	Arthritis	
	Arrhythmia (abnormal heart beat, for example atrial fibrillation)	
	Asthma	
	Autoimmune disease	
	Back problems	
	Bleeding disorder	
	Blood clot	
	Blood transfusion	
	Cancer	
	COPD/emphysema	
	Congestive heart failure (CHF)	
	Dementia	
	Depression	
	Diabetes	
	Disability	
	Gastrointestinal problem	
	Headaches/migraines	
	Heart attack/ coronary artery disease	
	Heart problem (other)	
	High blood pressure	
	High cholesterol	
	Kidney disease	
	Liver disease	
	Osteopenia/osteoporosis	
	Other brain or nerve disorder	
	Other mental health condition	
	Seizures	
	Sleep apnea	
	Stroke/TIA	
	Thyroid problem	
	Urinary problems	
	Other:	

□More listed on the back of this form

Please list any previous surgeries or procedures that you have had (including implanted devices like pacemakers):

Surgery/procedure	Reason	Year

□More listed on the back of this form

Please list any previous hospitalizations you have had:

Reason for being admitted	Hospital	Date

□More listed on the back of this form

What prescription medications do you take?

Medication	Dose	How many times per day	Reason for taking

□More listed on the back of this form

What over the counter medications do you take regularly?

Medication	Dose	How many times per day	Reason for taking

□More listed on the back of this form

What vitamins, herbs, or other supplements do you take regularly?

Medication	Dose	How many times per day	Reason for taking

□More listed on the back of this form

Please list any allergies you have (including medications, foods, latex, etc)

Allergic to:	Type of reaction (hives, breathing problem, etc)

□More listed on the back of this form

Please list any other medical providers you see (specialists, therapists, etc)

Provider name	Medical condition

□More listed on the back of this form

Vaccines:

Do you believe that you received all of your childhood immunizations? □ Yes □ No

Vaccine	Date(s)
Pneumonia	
HPV	
Shingles	
Last tetanus	
Last flu	

Preventive health:

When was your last primary care appointment? _____

When was your last wellness visit/"annual"? _____

When was your last colonoscopy? _____

When was your last cholesterol screening? _____

When was your last dental appointment? _____

When was your last eye exam? _____

Female (or assigned female at birth):

Last mammogram: _____

Have you ever had an abnormal mammogram? □ No □ Yes- date: _____

Last pap smear: _____

Have you ever had an abnormal pap smear? □ No □ Yes- date: _____

If premenopausal, first day of your last menstrual period: _____

Do you have regular periods? □ Yes □ No

Are you currently pregnant? □ Yes □ No

Are you currently breastfeeding? □ Yes □ NoIf postmenopausal, in what year was your last period?

_____

Last bone density test: _____

How many times have you been pregnant? _____

How many children have you had that were full term? _____

How many children have you had that were premature? _____

How many times did you have a pregnancy that ended in abortion? _____

How many times did you have a pregnancy that ended in miscarriage? _____

Social History

Gender/Sexual identity
What is your gender identity? □ Male □ Female □ Transgender male □ Transgender female □ Gender non-conforming □ _____
What was your assigned sex at birth? □ Male □ Female □ _____
What are your pronouns? □ He/him □ She/her □ They/their □ _____
What is your sexual orientation? □ Lesbian, gay, or homosexual □ Straight or heterosexual □ Bisexual □ _____

Personal/Employment
Are you employed? □ Yes □ No
If yes, what is your job? _____
If no, are you: □ Looking for work □ Not looking for work □ Disabled □ Retired- former occupation: _____
Marital status: □ single □ married □ domestic partner □ separated □ divorced □ widowed
Who lives with you? _____
How many children do you have? _____
What is the highest grade level or degree you achieved? _____
Do you have religious or cultural concerns that affect how we provide your medical care? _____
_____
Do you have advanced directives (for example, medical power of attorney or record of your end-of-life wishes)? □ Yes □ No

Alcohol use:
Do you drink alcohol? □ Yes □ No
If so, how often? _____
How many drinks each time? _____

Drug use:
Do you use any drugs (other than medications that a doctor prescribed to you)? □ Yes □ No
If yes, which ones? _____
Have you used drugs in the past? □ Yes □ No
If yes, describe: _____

Tobacco use:
Do you smoke?
□ Current smoker: Packs per day: _____
# of years: _____
□ Former smoker: Packs per day: _____
# of years: _____
Quit date: _____
□ Never smoked
□ Other tobacco/nicotine use: _____

Sexual activity
Are you currently sexually active? □ Yes □ No
How many sexual partners have you had in the last 3 months? ____
Who do you have sex with? □Men □Women □Both
Do you use condoms? □ Always □ Never □ Sometimes
Do you use other forms of birth control? □ Always □ Never □ Sometimes

Lifestyle:
How often do you exercise? _____
What type? _____
Are you on any special diets? _____
How many servings of caffeine do you drink daily? ____

Safety and Mobility
Do you have difficulty hearing? □ Yes □ No
Do you have difficulty seeing? □ Yes □ No
Do you have any difficulty caring for yourself? □ Yes □ No
Do you have any difficulty making ends meet at the end of the month? □ Yes □ No
Do you have concerns about meeting basic needs (food, housing, heat, etc)? □ Yes □ No
Do you have reliable transportation to and from your doctor's appointments? □ Yes □ No
Do you use any devices to help you get around (cane, wheelchair, etc)?: _____
Do you use seatbelts routinely? □ Yes □ No
Do you have smoke alarms in your home? □ Yes □ No
Do you wear sunscreen routinely ? □ Yes □ No

Family History

Family member	If living- current age	If deceased- age at time of death	Medical conditions they have/had and age they were diagnosed
Father			
Mother			
Paternal grandfather			
Paternal grandmother			
Maternal grandfather			
Maternal grandmother			
Siblings: (list)			
Children: (list)			
Other:			

□ I was adopted and do not know my biological family history

Review of symptoms

(please check the following symptoms you have had in the past 2 weeks)

General Symptoms:

☐Fever ☐Chill ☐Sweats ☐Fatigue
☐Feeling of ill health ☐Sleep problems
☐Weight loss ☐Weight gain ☐Other
Comments:

Eyes, Ears, Nose & Throat:

☐Vision loss ☐Blurry vision ☐Double vision
☐Blind spot ☐Flashing lights ☐Irritated eye
☐Eye discharge ☐Eye pain ☐Eye redness
☐Earache ☐Ear discharge ☐Ringing in the ears
☐Nasal congestion ☐Runny nose ☐Sore throat
☐Hoarseness ☐Dental problems
☐Clearing throat often ☐Loss of hearing
☐Hearing aids ☐Nose bleeds ☐Sinus pressure
☐Swallowing problems ☐Other
Comment:

Heart symptoms:

☐Chest pain ☐Rapid heart rate
☐Light headedness ☐Fainting
☐Shortness of breath laying down
☐Shortness of breath waking up
☐Blue skin or fingernail beds ☐Leg swelling
☐Other
Comment:

Lung Symptoms:

☐Cough – Dry ☐Coughing up mucus
☐Coughing up blood ☐Difficulty breathing
☐Wheezing ☐Chest pain with breathing
☐Snoring ☐Other
Comment:

Gastrointestinal Symptoms:

☐Nausea ☐Vomiting ☐Vomiting blood
☐Diarrhea ☐Constipation
☐Change in bowel movements
☐Abdominal pain ☐Black stools ☐Hemorrhoids
☐Yellow skin or eyes ☐Other
Comment:

Genitourinary Symptoms:

☐Urinating often ☐Urgent need to urinate
☐ Burning during urination ☐Blood in urine
☐Pain in your side ☐Urinary incontinence
☐Decreased interest in sex
☐Discharge from penis ☐Pain in scrotum
☐Swelling in penis or scrotum
☐Genital swelling ☐Genital order
☐Erection problems ☐Waking at night to urinate
☐Hard to keep stream going ☐Genital sores
☐Vaginal discharge ☐Problems with periods
☐Hot flashes ☐Vaginal dryness ☐Pelvic pain
☐Other
Comment:

Musculoskeletal Symptoms:

☐Muscle cramps ☐Muscle weakness
☐Joint pain ☐Joint swelling ☐Joint stiffness
☐Neck pain ☐Restless legs ☐Other
Comment:

Skin Symptoms:

☐Rash ☐Sores ☐Dry skin ☐Itching
☐Changes in color ☐New mole or growth ☐Nail changes ☐Hair changes ☐Other
Comment:

Breast Symptoms:

☐Breast lump ☐Breast pain ☐Nipple discharge
☐Nipple changes ☐Other
Comment:

Neurological Symptoms:

☐Frequent/severe headaches
☐Burning or prickling feeling ☐Numbness
☐Part of the body is weaker ☐Speech difficulties
☐Seizure or convulsions ☐Balance problems
☐Falls Difficulty walking ☐Shaking or tremors
☐Other
Comment:

Mental Health Symptoms:

☐Feeling low, sad or depressed ☐Anxiety
☐Panic ☐Fear or worry
☐Difficulty in concentrating
☐Thoughts of hurting self or others
☐Feeling that people are out to get you
☐Overly afraid of something
☐Seeing or hearing things that can't be real
☐Inability to feel pressure ☐Other
Comment:

Endocrine Symptoms:

☐Easy bleeding ☐Always feel cold
☐Always thirsty ☐Other
Comment:

Blood Related Symptoms:

☐Easy bleeding ☐Easy bruising ☐Swollen glands
☐Other
Comment:

Allergy and Immunology Symptoms:

☐Hives ☐Seasonal changes ☐Itchy eyes/nose
☐History of frequent infections ☐Other
Comment: