

Patient Name: _____ Date of Birth: _____

Preferred name, if other than given name: _____ Phone number: _____

Welcome to Michigan State University Health Care. 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) _____

Allergies (including medications, foods, latex, etc.): _____

More listed on the back of this form

	Reason	Dose	Frequency
Prescription Medications:			
Over the counter Medications:			
Vitamins, Herbs, & Supplements:			

Did you receive all of your childhood immunizations? No Yes Unsure

Date of last Pneumonia Shot: _____ Date of last Tetanus Shot: _____

Date of last HPV Shot: _____ Date of last Shingles Shot: _____ Date of last Flu Shot: _____

IF FEMALE (OR ASSIGNED FEMALE AT BIRTH), FINISH THIS PAGE. ALL OTHERS PROCEED TO NEXT PAGE.

Date of last Mammogram: _____ Abnormal Mammogram No Yes

Date of last Pap Smear: _____ Abnormal Pap Smear No Yes

Date of last period (premenopausal): _____ Date of last period (postmenopausal): _____

Regular periods No Yes Number of pregnancies: _____

Currently pregnant No Yes Number of full term pregnancies: _____

Currently breastfeeding No Yes Pregnancies that ended in abortion No Yes

Pregnancies that ended in miscarriage No Yes

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FAMILY HISTORY

Check any medical conditions that apply past or present:

 I was adopted & do not know my biological family history

	Self	Mother	Father	Brother/Sister	Grandparent	Comment
ADHD						
Acid reflux (GERD)						
Addiction to alcohol or drugs						
Allergies (environmental/seasonal)						
Anemia (low blood count)						
Anxiety						
Arthritis						
Arrhythmia (abnormal heart beat, such as atrial fibrillation)						
Asthma						
Autoimmune disease						
Back problems						
Bleeding disorder						
Blood clot						
Blood transfusion						
Cancer						
COPD/emphysema						
Congestive heart failure (CHF)						
Dementia						
Depression						
Diabetes						
Disability						
Fractures						
Gastrointestinal problem						
Headaches/migraines						
Heart attack/ coronary artery disease						
Heart problem (other)						
High blood pressure						
High cholesterol						
Kidney disease						
Liver disease						
Methicillin-Resistant Staphylococcus Aureus (MRSA) infection						
Osteopenia/osteoporosis						
Other brain or nerve disorder						
Other mental health condition						
Seizures						
Sleep apnea						
Stroke/TIA						
Thyroid problem						
Urinary problems						
Other:						

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SOCIAL HISTORY**GENDER/SEXUAL IDENTITY**What is your birth sex? Male Female OtherWhat is your sexual orientation? Homosexual Heterosexual Bisexual _____What is your gender identity? Male Female Transgender Genderqueer _____What are your pronouns? He/him She/her They/their _____**PERSONAL/EMPLOYMENT**Are you employed? No Yes

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? _____

Highest grade level/degree achieved: _____

Describe any religious or cultural concerns that affect how we provide your medical care:
_____Do you have advanced directives (medical power of attorney, record of your end-of-life wishes, etc.)? No Yes**ALCOHOL USE**Do you drink alcohol? No Yes

If yes, how often? _____

How many drinks each time? _____

DRUG USEDo you use any drugs (other than medications that a doctor prescribed to you)? No Yes

If yes, which ones? _____

Have you used drugs in the past? No Yes

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? No Yes

Number of sexual partners in the last 3 months? _____

Who do you have sex with? Men Women BothDo 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? No YesDo you have difficulty seeing? No YesDo you have difficulty caring for yourself? No YesDo you have difficulty making ends meet at the end of the month? No YesDo you have concerns about meeting basic needs (food, housing, heat, etc)? No YesDo you have reliable transportation to and from your doctor's appointments? No Yes

Do you use any devices to help you get around (cane, wheelchair, etc)? _____

Do you use seat belts routinely? No YesDo you have smoke alarms in your home? No YesDo you wear sunscreen routinely? No Yes**CONTINUED ON NEXT PAGE**

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REVIEW OF SYMPTOMS

Check any of the following symptoms you have experienced in the past 2 weeks:

GENERAL

- Fever Chills Sweats Fatigue
Feeling of ill health Sleep problems
Weight loss Weight gain Other
Comment: _____

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 Loss of hearing
Clearing throat often Hearing aids
Nose bleeds Sinus pressure
Swallowing problems Other
Comment: _____

HEART

- Chest pain Rapid heart rate
Lightheadedness Fainting
Shortness of breath laying down
Shortness of breath waking up
Blue skin or fingernail beds
Leg swelling Other
Comment: _____

LUNG

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

GASTROINTESTINAL

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

GENITOURINARY

- 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 odor
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

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

SKIN

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

BREAST

- Breast lump Breast pain
Nipple discharge
Nipple changes Other
Comment: _____

NEUROLOGICAL

- 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

- 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
Other
Comment: _____

ENDOCRINE

- Always feel cold Always thirsty
Other
Comment: _____

BLOOD RELATED

- Easy bleeding Easy bruising
Low blood/anemia Swollen glands
Females: Bleeding during or after delivery (post-partum hemorrhage)
Other
Comment: _____

ALLERGY & IMMUNOLOGY

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