Help Us Help You

Kentwood Family Physicians, P.C.
Board Certified Family Physicians

This HEALTH HISTORY is an important step in making quality health care available to you and your family. Please answer the questions below. This information will be kept confidential and used for your continuing care. If your primary care physician is new to you or if you have a problem, please make an appointment as soon as possible.

(PLEASE PRINT)

Primary Care Physician _____

Patient's name _____ Birthdate _____

Person completing this history _____ Date _____

As an adult, list your:

1. Height _____ 2. Highest weight _____ lbs. 3. Lowest weight _____ lbs. 4. Present weight _____ lbs.

MEDICAL HISTORY:

Have you ever had or do you now have any of the problems listed below?

	YES	NO		YES	NO		YES	NO	
5.	☐	☐	AIDS	18. ☐	☐	Depression	31. ☐	☐	Mononucleosis
6.	☐	☐	Anemia (Low Blood)	19. ☐	☐	Epilepsy	32. ☐	☐	Phlebitis (Blood Clot in Veins)
7.	☐	☐	Other blood disorder	20. ☐	☐	Eye disease	33. ☐	☐	Sexually transmitted disease (Gonorrhea, Herpes, Syphilis)
8.	☐	☐	Arthritis/Rheumatism	21. ☐	☐	Gall bladder disease	34. ☐	☐	Sickle Cell
9.	☐	☐	Asthma	22. ☐	☐	Gout	35. ☐	☐	Sinus
10.	☐	☐	Back trouble	23. ☐	☐	Heart trouble	36. ☐	☐	Stroke
11.	☐	☐	Bleeding tendencies	24. ☐	☐	Hepatitis/Jaundice	37. ☐	☐	Stomach trouble/Ulcers
12.	☐	☐	Bronchitis/Pneumonia	25. ☐	☐	Hemorrhoids	38. ☐	☐	Thyroid problems
13.	☐	☐	Emphysema	26. ☐	☐	Hernia	39. ☐	☐	German measles (Rubella)
14.	☐	☐	Cancer/Tumor	27. ☐	☐	High blood pressure	40. ☐	☐	Tuberculosis
15.	☐	☐	Colitis/Bowel problems	28. ☐	☐	Hypoglycemia	41. ☐	☐	Have you ever had a positive TB test?
16.	☐	☐	Convulsions (Seizures)	29. ☐	☐	Kidney/Bladder trouble			If yes, when? _____
17.	☐	☐	Diabetes (Sugar)	30. ☐	☐	Migraine headaches	42.		Year of last Tetanus shot _____

43. List any surgery (operations) _____

44. List any allergic reactions or sensitivities to medicine _____

_____

45. List any medications you are currently taking _____

_____

Have you had trouble with:

	YES	NO		YES	NO		YES	NO	
46.	☐	☐	Allergies	53. ☐	☐	Chronic cough	60. ☐	☐	Bowel problems (Such as)
47.	☐	☐	Abdominal pain	54. ☐	☐	Coughing up blood	61. ☐	☐	Constipation
48.	☐	☐	Vision	55. ☐	☐	Chest pain	62. ☐	☐	Diarrhea
49.	☐	☐	Hearing	56. ☐	☐	Sleeping	63. ☐	☐	Change in bowel habits
50.	☐	☐	Excessive bleeding	57. ☐	☐	Dizziness/Fainting	64. ☐	☐	Rectal bleeding
51.	☐	☐	Headaches	58. ☐	☐	Fatigue/Tiredness	65. ☐	☐	Heartburn/Indigestion
52.	☐	☐	Shortness of breath	59. ☐	☐	Confusion/Loss of memory			

Write in your approximate age at which you had any of these illnesses:

66. _____ Chickenpox
67. _____ Smallpox
68. _____ German (3 day) measles
69. _____ Hard measles
70. _____ Diphtheria
71. _____ Mumps
72. _____ Scarlet fever
73. _____ "Strep" throat

How much per day do you:

74. Smoke: _____ Cigars _____ Pipe _____ Packs of cigarettes
75. Drink: _____ Cups of coffee/tea
_____ liquor _____ beer
76. Drugs: _____
77. Other: _____

FAMILY HISTORY:

Check if there is a history in your immediate family (blood relatives) of any of the following:

78. ☐ Anemia/Bleeding tendencies
79. ☐ Sickle cell
80. ☐ Mental illness
81. ☐ Suicide
82. ☐ Cancer _____ (type)
83. ☐ Stroke
84. ☐ Gout
85. ☐ High blood pressure
86. ☐ Heart disease
87. ☐ Alcoholism
88. ☐ Epilepsy
89. ☐ Diabetes

90. If a parent, brother/sister has died, please list age and cause of death: _____

Please answer the following—Are you:

	YES	NO	
91.	☐	☐	Often dissatisfied with your work
92.	☐	☐	Tense, fearful
93.	☐	☐	Often dissatisfied with your sexual life
94.	☐	☐	Sad, depressed
95.	☐	☐	Hopeless, "ending it all"

FOR MEN—Have you ever had:

	YES	NO	
96.	☐	☐	Problems with urination
97.	☐	☐	Testicular pain/swelling
98.	☐	☐	Prostate trouble
99.	☐	☐	Impotence
100.	☐	☐	Do you regularly perform testicular exams?

FOR WOMEN—

Have you ever had problems with:

	YES	NO	
101.	☐	☐	Breast lumps, pain or discharge from nipples
102.	☐	☐	Do you regularly perform self breast exams?
103.	☐	☐	Vaginal discharge
104.	☐	☐	Uterine infection
105.	☐	☐	Menstrual period
106.	☐	☐	Bleeding between periods
107.	☐	☐	Does your monthly cycle interfere with daily activities?
108.	☐	☐	Did your mother take any drugs (D.E.S.) to prevent miscarriage while pregnant with you?

Menstrual History:

109. _____ Age periods started
110. _____ Number of days of flow
☐ Light flow
☐ Moderate flow
☐ Heavy flow
111. _____ Number of days from 1st day of one period to 1st day of next period
112. _____ Number of periods you have per year

Pregnancy History:

113. _____ Number of pregnancies
114. _____ Number of live births
115. _____ Number of premature births
116. _____ Number of miscarriages
117. _____ Number of abortions
118. _____ Number of living children
____ Oldest ____ Youngest
119. _____ Date when last pregnancy ended (month/year)
120. _____ Do you think you are pregnant now?

121. Do you expect to need medical care in the near future? ☐ Yes ☐ No If yes, for what reason? _____

122. Explain any yes answers from above questions: _____

Completed by _____ Date _____

Reviewed by _____ Date _____
Physician's Signature