COMPEAN
FAMILY MEDICINE

327 Stewart Road
Monroe, MI 48162

734-384-3660 phone
734-384-3661 fax

PATIENT HEALTH HISTORY

Today's Date _____

Patient's Name _____ Date of Birth ____/____/_____

MEDICAL CONDITIONS: Check (√) conditions you currently have or have had in the past.

□ AIDS	□ Emphysema	□ Liver Disease	□ Stroke
□ Alcoholism	□ Epilepsy	□ Measles	□ Suicide Attempt
□ Anemia	□ Gonorrhea	□ Migraine Headaches	□ Thyroid Problems
□ Aneurysm	□ Gout	□ Miscarriage	□ Ulcers
□ Arthritis	□ Heart Attack	□ Mononucleosis	□ Vaginal Infections
□ Asthma	□ Heart Disease	□ Multiple Sclerosis	□ Venereal Disease
□ Bleeding Disorder	□ Heartburn	□ Mumps	□ Other _____
□ Breast Lump	□ Hepatitis	□ Neuropathy	□ Other _____
□ Cancer	□ Hernia	□ Pacemaker	□ Other _____
□ Chemical Dependency	□ Herpes	□ Pneumonia	□ Other _____
□ Congestive Heart Failure	□ High Blood Pressure	□ Polio	
□ Chicken Pox	□ High Cholesterol	□ Prostate Problem	
□ COPD	□ HIV Positive	□ Psychiatric Care	
□ Diabetes	□ Kidney Disease	□ Rheumatic Fever	
□ Eating Disorder	□ Kidney Stones	□ Scarlet Fever	

Have you ever had a blood transfusion? □ Yes □ No If yes, please give dates. _____

SURGICAL HISTORY: Type of Surgery	Date of Surgery	Where was surgery performed?

MEDICATIONS: List medications you are currently taking. NAME OF MEDICATION	MEDICATION DOSAGE AND DIRECTIONS

LIST YOUR ALLERGIES AND REACTION to medications, foods or substances:

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PATIENT HEALTH HISTORY – PAGE 2

SOCIAL HISTORY: Check (√) which you use(d)		Describe how much you use(d) and for how long
	Alcohol	
	Caffeine	
	Drug Abuse	
	Tobacco	

FAMILY HISTORY: Fill in health information about your family.

Relationship	Age	Age at Death	Cause of Death	DESCRIBE ANY MEDICAL CONDITIONS
Father				
Mother				
Brothers				
Sisters				

OB/GYN HISTORY: Fill in your OB/GYN health history.

Age at first period		How many pregnancies?	
Date of last menstrual period		How many full term pregnancies?	
How often do your periods occur?		How many pre-term pregnancies?	
How long do your periods last?		How many miscarriages?	
Have you had an abnormal pap smear? If yes, when.		How many abortions?	

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PATIENT HEALTH HISTORY – PAGE 3

REVIEW OF SYSTEMS: Check (√) symptoms you currently have.

- □ Fever
- □ Night sweats
- □ Weight loss
- □ Weight gain/obesity
- □ Cataract
- □ Glaucoma
- □ Vision change
- □ Eye pain
- □ Eye discharge
- □ Eye swelling
- □ Eye redness
- □ Hearing loss
- □ Voice change
- □ Sinus congestion
- □ Ringing in ears
- □ Dizziness
- □ Nasal discharge
- □ Nose bleeding

- □ Chest pain/pressure
- □ Exercise intolerance
- □ Palpitations
- □ Difficulty breathing when lying down
- □ Cough
- □ Shortness of breath
- □ Sleep apnea
- □ Blood tinged sputum

- □ Abdominal pain
- □ Rectal bleeding/bloody stools
- □ Bloody vomit
- □ Change in bowel habits
- □ Change in caliber of stool
- □ Nausea
- □ Vomiting
- □ Black tarry stools
- □ Urinary urgency
- □ Urinary frequency
- □ Urinary retention/hesitancy
- □ Pain with urination
- □ Blood in urine
- □ Kidney stones
- □ Joint complaint
- □ Muscle weakness
- □ Red, hot, swollen joints
- □ Mole change

- □ Rash
- □ Skin cancer
- □ Eczema
- □ Psoriasis

- □ History of stroke
- □ Seizure
- □ Headache
- □ Speech difficulties
- □ Weakness in arms or legs

- □ Anxiety
- □ Alcohol abuse
- □ Depression
- □ Bipolar
- □ Suicidal tendencies
- □ Schizophrenia
- □ Drug abuse
- □ High blood sugar
- □ Low blood sugar
- □ Thyroid problems
- □ Goiter
- □ Abnormal bleeding and bruising
- □ Anemia
- □ Lymph node enlargement/mass
- □ Anaphylactoid reaction
- □ Food allergy
- □ Itchy eyes
- □ Sneezing

- □ Numbness