UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS

BIRTHDATE

NAME

REG. No.

Health Questionnaire

Date: ____________________

PHYSICIAN AND PHARMACY INFORMATION

Physician who referred you to this visit: ______________________ ☐ Self referred

Family physician:

Name ______________________ Specialty ______________________

Address ______________________ Telephone ( ) ______________________

City State Zip ______________________ Fax ( ) ______________________

Specialty physician (e.g., surgeon, oncologist, other):

Name ______________________ Specialty ______________________

Address ______________________ Telephone ( ) ______________________

City State Zip ______________________ Fax ( ) ______________________

Name ______________________ Specialty ______________________

Address ______________________ Telephone ( ) ______________________

City State Zip ______________________ Fax ( ) ______________________

Pharmacy

For most of our pharmacy needs, we use:

Name of Pharmacy ______________________

Address ______________________ Telephone ( ) ______________________

City State Zip ______________________ Fax ( ) ______________________

PRIMARY PURPOSE OF VISIT

List any issues or concerns to be addressed:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

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HISTORY

Hospitalizations/Surgeries/Other Medical Illnesses

Please list any hospitalizations, surgeries, or prior medical illnesses. Do not include normal pregnancies.

Date	Description

Have you ever had a transfusion or been exposed to other blood products? ☐ Yes ☐ No

Describe the situation: ____________________

Medications

Please list all medications you are currently taking, including those you buy without a doctor's prescription.

Name	Dose	Number per Day

Allergies and Sensitivities

Are you allergic to or had a bad reaction to any medicine or other element? ☐ Yes ☐ No Please describe:

Allergic to:	Reaction:

Illnesses and Medical Problems

Have you had any of the following illnesses? If so, please mark with an (X):

- ☐ Rheumatic fever
- ☐ Alcoholism
- ☐ Tuberculosis
- ☐ Heart attack
- ☐ Other: ____________
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ HIV
- ☐ High blood pressure
- ☐ ____________
- ☐ Emotional problems
- ☐ Thyroid trouble
- ☐ Venereal disease
- ☐ Emphysema
- ☐ ____________
- ☐ Hay fever
- ☐ Asthma
- ☐ Diabetes
- ☐ Stroke
- ☐ ____________

Gynecological History (Women)

At what age did you start menstruating? _____ years Last menstrual period: _____/_____/_____

Are you pregnant? ☐ yes ☐ no Number of prior pregnancies _____ miscarriages _____ abortions _____

Onset of menopause: _____ month _____ year

Last Pap smear: _____/_____/_____ Last mammogram: _____/_____/_____

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SOCIAL/PERSONAL HISTORY

Currently live: ☐ Alone ☐ With family ☐ With friends ☐ With significant other
Marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never married
Occupation: ______________ Hobbies: ______________
Do you have children? ☐ Yes ☐ No Ages: ______________
Do you smoke? ☐ Yes ☐ No Amount per week ______ per day ______ Duration of habit ______ (yrs)
Chew tobacco? ☐ Yes ☐ No Amount per week ______ per day ______ Duration of habit ______ (yrs)
How would you describe your use of alcohol? ______________
Amount per week of beer ______ Wine ______ Liquor ______
Do you use drugs? ☐ Yes ☐ No Type ______________

FAMILY HEALTH HISTORY

Please check if any blood relative has had any of the following:

☐ Heart attack ☐ Alcoholism ☐ Tuberculosis (TB) ☐ Lupus
☐ Diabetes (sugar) ☐ Emphysema ☐ Easy bleeding ☐ Stroke
☐ High blood pressure ☐ Arthritis ☐ Cirrhosis ☐ Asthma
☐ Anemia ☐ Thyroid (goiter) ☐ Other: ______ ☐ ______
☐ Cancer Which type: ______ Relationship to you: ______
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☐ Cancer Which type: ______ Relationship to you: ______

REVIEW OF SYSTEMS

Please circle any of the following which apply to you.

Category	Issues	No problems
General	appetite change, fatigue, fever, sweats, weight loss, weight gain, weakness	☐
Skin	itching, rash, mole change	☐
Eyes	vision change, cataracts, glaucoma	☐
Ears/nose/mouth	dizziness, ringing in ears, hoarseness, sore throat	☐
Breasts	discharge, mass, pain, tenderness	☐
Lungs	cough, shortness of breath, chest pain, coughing blood, wheezing	☐
Heart	chest pain, palpitations, fainting episodes, leg pains, sleeping with more than one pillow	☐
GI	abdominal pain, nausea, vomiting, diarrhea, constipation, jaundice, black stools, blood in stools, difficulty swallowing, hemorrhoids	☐
Genito-urinary	painful urination, increased frequency, urgency, blood in urine, kidney stones, urinating at night	☐
Musculo-skeletal	arthritis, stiffness, swelling, weakness, backache	☐
Nervous system:	headache, seizure, dizziness, tremors, memory loss, paralysis, numbness/tingling, anxiety, depression, personality change, suicidal thoughts	☐
Male reproductive	testicular pain, swelling, sexual dysfunction	☐
Female reproductive	pelvic pain, loss of period, abnormal bleeding, sexual dysfunction	☐
Hematologic	bruising, bleeding, recurrent infections	☐
Lymph nodes	enlargement, tenderness	☐

Patient Signature: ______________ Date: ______
Last reviewed by: ______________ Title ______________ Date ______