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

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<th>Reason</th>
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Prescription Medications:

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Over the counter Medications:

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Vitamins, Herbs, & Supplements:

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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  □ Unsure
Date of last Pap Smear: ________________  Abnormal Pap Smear  □ No  □ Yes
Date of last period (premenopausal): ________________  Date of last period (postmenopausal): ________________
Regular periods  □ No  □ Yes
Currently pregnant  □ No  □ Yes
Currently breastfeeding  □ No  □ Yes
Number of pregnancies: ________________
Number of full term pregnancies: ________________
Pregnancies that ended in abortion  □ No  □ Yes
Pregnancies that ended in miscarriage  □ No  □ Yes

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<th>Family History</th>
<th>Self</th>
<th>Mother</th>
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<th>Brother/Sister</th>
<th>Grandparent</th>
<th>Comment</th>
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<td>ADHD</td>
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<td>Acid reflux (GERD)</td>
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<td>Addiction to alcohol or drugs</td>
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<td>Allergies (environmental/seasonal)</td>
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<td>Anemia (low blood count)</td>
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<td>Anxiety</td>
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<td>Arthritis</td>
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<td>Arrhythmia (abnormal heart beat, such as atrial fibrillation)</td>
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<td>Asthma</td>
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<td>Autoimmune disease</td>
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<td>Bleeding disorder</td>
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<td>Cancer</td>
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<td>COPD/Emphysema</td>
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<td>Congestive heart failure (CHF)</td>
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<td>Diabetes</td>
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<td>Disability</td>
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<td>Fractures</td>
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<td>Gastrointestinal problem</td>
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<td>Headaches/migraines</td>
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<td>Heart attack/ coronary artery disease</td>
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<td>Kidney disease</td>
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<td>Liver disease</td>
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<td>Methicillin-Resistant Staphylococcus</td>
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<td>Aureus (MRSA) infection</td>
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<td>Osteopenia/osteoporosis</td>
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<td>Seizures</td>
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<td>Sleep apnea</td>
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<td>Stroke/TIA</td>
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<td>Thyroid problem</td>
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<td>Urinary problems</td>
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Patient Name: _____________________________________________ Date of Birth: ______________________

SOCIAL HISTORY

GENDER/Sexual Identity

What is your birth sex? □Male □Female □Other

What is your sexual orientation? □Homosexual
□Heterosexual □Biexual □ __________________________

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 attor-
ney, 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 USE

Do 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 □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? □No □Yes
Do you have difficulty seeing? □No □Yes
Do you have difficulty caring for yourself? □No □Yes
Do you have difficulty making ends meet at the end of
the month? □No □Yes
Do you have concerns about meeting basic needs (food,
housing, heat, etc)? □No □Yes
Do 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 □Yes
Do you have smoke alarms in your home? □No □Yes
Do you wear sunscreen routinely? □No □Yes

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<th>Surgeries/Procedures: (including implanted devices like pacemakers)</th>
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<th>Hospitalizations: (Please list any previous hospitalizations you have had)</th>
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<th>Other Medical Providers: (specialists, therapists, etc)</th>
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Date of last Primary Care Appt: ___________________  Date of last Annual Visit: ___________________
Date of last Colonoscopy: ______________________  Date of last Cholesterol Screening: ___________
Date of last Dental Appointment: ________________  Date of last Eye Exam: _________________
Date of last Bone Density: _________________
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:

### 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:

### 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:

### MUSCULOSKELETAL
- □ Muscle cramps
- □ Muscle weakness
- □ Joint pain
- □ Joint swelling
- □ Joint stiffness
- □ Neck pain
- □ Restless legs
- □ Other
- Comment:

### ALLERGY & IMMUNOLOGY
- □ Hives
- □ Seasonal changes
- □ Itchy eyes/nose
- □ History of frequent infections
- □ Other
- Comment:

### BLOOD RELATED
- □ Easy bleeding
- □ Easy bruising
- □ Low blood/anemia
- □ Swollen glands
- Females: □ Bleeding during or after delivery (post-partum hemorrhage)
- □ 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:

### 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
- □ 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: