SINDECUSE HEALTH CENTER

WESTERN MICHIGAN UNIVERSITY

CONFIDENTIAL HEALTH HISTORY

Date:_____

Name:_____

Last (Family) First Middle

Age:_____ Date of Birth: _____Height:_____ Weight:_____ Sex: Male ☐ Female ☐

Local Home

Address:_____

Number & Street City State Zip Code

_____

Phone Cell

Permanent Home

Address:_____

Number & Street City State/Province Zip Code

_____

Country Phone

Notify in Emergency:_____

Name Relationship

_____

Number & Street City State/Province Zip Code

_____

Country Phone

DRUG ALLERGIES

_____

MEDICAL MATERIAL ALLERGIES (i.e. latex, contrast dye, etc.)

_____

MEDICINES

Please list any medicines you take regularly (include vitamins and nonprescription medications).

_____

1. What are you being seen for today?_____

When did this problem begin?_____

Was there a specific injury?_____ If yes, what happened?_____

What makes the problem worse?_____

What makes the problem better?_____

Are there any associated symptoms (locking, catching, giving out, numbness, etc.)?_____

_____

What treatment has been done thus far?_____

2. Family Medical History

Have any of the following illnesses occurred in a blood relative (parents, brothers, sisters, grandparents)?

			Which family member?
Yes	No	Cancer	
Yes	No	Heart Disease, heart attack	
Yes	No	High Blood Pressure	
Yes	No	Diabetes	
Yes	No	Stroke	
Yes	No	Rheumatoid arthritis	
Yes	No	Bleeding Tendency/DVT (blood clots)	
Yes	No	Allergies/Asthma/Emphysema/Lung Disease	
Yes	No	Migraine headaches	
☐	Other:_____		

3. Personal Medical History – Have you had or do you now have any of the following?

Yes	No	Cancer	Yes	No	Pregnancy
Yes	No	Hearth Disease, heart attack	Yes	No	Hypoglycemia
Yes	No	High Blood Pressure	Yes	No	Kidney/bladder infection
Yes	No	Diabetes	Yes	No	Seizure disorder
Yes	No	Stroke	Yes	No	Dizziness
Yes	No	Rheumatoid arthritis	Yes	No	Tuberculosis
Yes	No	Osteoporosis	Yes	No	Liver Disease/Hepatitis
Yes	No	Bleeding tendency/DVT (blood clots)	Yes	No	Stress Fracture/Fracture
Yes	No	Allergies/Asthma/Emphysema/Lung Disease	Yes	No	Eating Disorder
Yes	No	Migraine headaches	Yes	No	Stomach Ulcers
Yes	No	HIV	☐	Other:_____	

4. Surgical History (list any surgeries) _____

_____

5. Social History

a. Occupation or School/grade:_____
b. Do you smoke?_____ If yes, how much?_____
c. Do you drink alcohol? _____ If yes, how much?_____
d. In which sports or fitness activities do you participate?_____

6. Review of Symptoms (check symptoms that you are experiencing):

☐ Joint Swelling	☐ Abdominal Pain	☐ Depression
☐ Joint Stiffness	☐ Nausea	☐ Confusion
☐ Weakness	☐ Diarrhea	☐ Poor Concentration
☐ Numbness	☐ Constipation	☐ Irregular or Missed Periods
☐ Tingling	☐ Urinary Incontinence	☐ Easy Bleeding
☐ Chest Pain	☐ Urinary Frequency	☐ Problems with Anesthesia
☐ Palpitations	☐ Pain with Urination	☐ Other:_____
☐ Dizziness	☐ Skin Rash	
☐ Shortness of Breath	☐ Hair Loss/Thinning	
☐ Persistent Cough	☐ Fatigue	
☐ Productive Cough	☐ Fever	
☐ Cough with blood	☐ Unexplained Weight Loss/Gain	
	☐ Night Sweats	

By signing below, I attest that I have personally reviewed the information on this sheet

PATIENT SIGNATURE:_____ **DATE:**_____

PHYSICIAN SIGNATURE:_____ **DATE:**_____

4/22/09tt