BLANZY CLINIC- HEALTH HISTORY FORM

14319 Dix-Toledo Southgate, MI 48195 734-285-0677 fax 734-285-3574

DATE: ____________________ PATIENT NUMBER ________________

IDENTIFICATION INFORMATION

NAME- LAST ______ FIRST ______ MIDDLE ______ BIRTHDATE ______

ADDRESS - NUMBER AND STREET ______ CITY ______ STATE ______ ZIP ______

PHONE # ______ CELL PHONE # ______

CURRENT MEDICAL PROBLEMS

If you are being treated for any other illnesses or medical issues by another physician, please describe the problems and indicate the name of the physician treating you..

ILLNESS OR PROBLEM	PHYSICIAN TREATING YOU

ILLNESS AND MEDICAL PROBLEMS

please circle yes or no to any illnesses you currently or previuosly had and the year it began.

Illness	circle	year	Illness	circle	year
Eye or eye lid infection	Y N		Yellow Jaundice	Y N	
Glaucoma	Y N		Liver trouble	Y N	
other eye problems	Y N		Gallbladder trouble	Y N	
Deafness	Y N		Hernia	Y N	
Ringing in ears	Y N		Hemmorrhoids	Y N	
Bronchitis	Y N		Kidney or bladder	Y N	
Emphysema	Y N		Prostate problem	Y N	
Pneumonia	Y N		Epilepsy	Y N	
Allergies or Asthma	Y N		Head Injury	Y N	
Tuberculosis	Y N		Stroke	Y N	
Lung Problems	Y N		Convulsions, Seizures	Y N	
High Blood Pressure	Y N		Arthritis	Y N	
Heart Attack	Y N		Cancer or Tumor	Y N	
High Cholesterol	Y N		Bleeding Tendency	Y N	
Arteriosclerosis	Y N		Diabetes	Y N	
Heart Murmur	Y N		Hepatitis	Y N	
Other Heart Condition	Y N		Measles	Y N	
Stomach Ulcer- duodenal	Y N		Mononucleosis	Y N	
Diverticulitis	Y N		Psoriasis	Y N	
Gout	Y N		Mental Illness	Y N	

HOSPITALIZATIONS

please list the last 3 times that you have been hospitalized- do not include normal prenancy.

year	operation or illness	Hospital and City

System Review : Please check each item that you have now or have had in the past.

GENERAL:

____ weakness
____ fatigue
____ chills
____ night sweats
____ change in weight, appetite
or sleep habits

SKIN:

____ itching
____ rash
____ change in color
____ easy bruising

NERVOUS SYSTEM:

____ headaches
____ dizziness
____ double vision
____ muscle weakness
____ numbness

LUNGS:

____ cough
____ wheezing
____ shortness of breath
____ spitting up blood
____ positive TB test
Last chest X ray date ______________

HEART:

____ chest pain
____ palpitations(heart pounding)
____ trouble breathing at night
____ trouble climbing stairs
____ easy fatigue
____ ankle swelling

GASTROINTESTINAL:

____ stomach/ abdominal pain
____ indigestion/ heartburn
____ ulcers
____ difficulty swallowing
____ vomiting
____ changes in bowel habits
____ blood in stools
____ hemorrhoids

URINARY:

____ pain during urination
____ blood in urine
____ frequent urination
____ previous infections
____ kidney stones

IMMUNIZATIONS:

Polio Vaccine date ______________
Tetanus Vaccine date ______________

EYES:

____ glasses / contacts
____ eye pain
____ excessive tearing
Last eye exam date ______________

EARS:

____ loss of hearing
____ ringing
____ drainage

NOSE/ THROAT/ SINUS:

____ nosebleed
____ sorethroat
____ hoarseness
____ post nasal drip
____ swelling

MOUTH:

____ dentures
____ bleeding gums
____ toothache
Last dental exam ______________

JOINTS AND BACK :

____ pain
____ swelling
____ stiffness
____ deformity

MUSCLES:

____ pain
____ weakness
____ twitching

ENDOCRINE:

____ excessively hot
____ excessively cold
____ always thirsty
____ always hungry

PSYCHOLOGICAL:

____ nervousness
____ depression
____ unable to sleep
____ nightmares
____ memory loss

MALE: please check all that apply

___ hernia ___ pain in testicle(s

___ discharge from penis

___ VD ___ sexual difficulties

FEMALE: please check all that apply

___ vaginal itching or burning ____vaginal discharge

___ problems with menstrual periods

___ VD _____ sexual difficulties

___ discharge from nipples ____lumps in breast(s)

Last Mammogram date ____________

Last menstrual cycle _______ Last Papsmear date _________

Pregnancy- Y or N number _____ Miscarraiges or abortions_________

SOCIAL - PERSONAL HISTORY

You currently live : _____alone _____with family _____with friends

You are : ____married _____ separated ______divorced ______widowed _____never married

Type of work you do: ____

Last grade completed in school: ____________

Have you ever been rejected for health reasons by the Military, Employer, or Insurance Company?

______ if yes, please explain ____

Were you sick , but failed to get medical care in the last year? _________________________

Did you miss more than 10 days of your usual activity due to illness in the last year?

______ if yes, please explain____

Smoking History:
1. Do you currently smoke? ____________
2. How many packs per day? ____________
3. How many years? ________________
4. Are you a former smoker? ____________

Consumption of Alcoholic Beverages? __________________ ammount ________________

Do you use or have you used Marijuana? ___________________

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS			
SISTERS			
SPOUSE			
CHILDREN			

HAVE ANY BLOOD RELATIVES	HAD ANY OF THE FOLLOWING
ILLNESSES? INDICATE WHO?	PARENT? SIBLING? CHILD?
DIABETES	
CANCER	
BLOOD DISEASE	
GLAUCOMA	
EPILEPSY	
RHEUMATOID ARTHRITIS	
TUBERCULOSIS	
GOUT	
HIGH BLOOD PRESSURE	
HEART DISEASE	

Medications

Please list all medications you are currently taking:
RX and Over the Counter:

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________
7.____________________
8.____________________
9.____________________
10.____________________

Allergies and Sensitivites

allergic to: reaction:

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________

Other comments not covered above:

____
____
____

X____________________ X____________________
PATIENT SIGNATURE PHYSICIAN SIGNATURE