MICHIGAN MEDICINE Family Medicine **Health History Questionnaire – Family Medicine – 10 Years of Age and Younger**	MRN: NAME: BIRTHDATE: CSN:

Date of appointment: _____/_____/_____ (mm/dd/yyyy)

Please fill this form out as completely as possible and bring this to your appointment.

If you have filled out this form previously, please enter any changes in your health history that have occurred since the last visit.

Birth History

Birth Length_____ Birth Weight _____ Birth head circumference _____

Discharge Weight _____ Gestational Age _____

Delivery Method: ☐C-Section ☐Induction ☐Vaginal Duration of labor _____

Hospital Information: Days in hospital _____ Hospital name _____ Hospital location _____

APGAR Scores: APGAR 1 _____ APGAR 5 _____ APGAR 10 _____

Feeding method: ☐Bottle ☐Breast & Formula ☐Breast ☐Formula ☐Unknown

Additional Comments (including any problems after delivery):

Past Medical History (Please check any medical problems that you have had in the past)

☐Allergies
☐Anemia
☐Anxiety
☐Arthritis
☐Asthma
☐Blood transfusion
☐Cancer
☐Clotting disorder
☐Concussion
☐Other (list) _____
☐Other (list) _____
☐Congestive heart failure
☐Depression
☐Diabetes mellitus
☐GERD (heartburn)
☐Glaucoma
☐Headaches
☐Heart murmur
☐HIV/AIDS
☐Hyperlipidemia (high cholesterol)
☐Hypertension (high blood pressure)
☐Hypothyroidism
☐Kidney disease
☐Liver disease
☐Nerve/muscle disease
☐Seizures
☐Sickle cell anemia
☐Sleep apnea
☐Stroke
☐Tuberculosis
☐Ulcers

Past Surgical History (Check any surgeries you have had and the date of surgery if you know it)

☐Appendectomy
☐Brain surgery
☐Colon surgery
☐Cosmetic surgery
☐Other(list)_____
☐Eye surgery
☐Fracture surgery
☐Hernia repair
☐Joint replacement
☐Other(list)_____
☐Small intestine surgery
☐Spine surgery
☐Tonsillectomy and Adenoidectomy
☐Valve replacement

☞ **FOR OFFICE STAFF: COLLECTED INFORMATION MUST BE ENTERED IN MICHART. DISCARD FORM AFTER ENTRY, USING CONFIDENTIAL RECYCLE. DO NOT SEND TO HIM.**

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Family History

Check below to report problems your family members have had. Please state the age when they had the problem if you know it. Please enter the name of the person in the blank.

☐Adopted (or limited/unknown family history)

	Mother	Father	Sister	Brother	Other (list)
Alcohol abuse					
Aneurysm					
Asthma					
Autoimmune disease					
Birth defects					
Breast cancer					
Cancer					
Colon cancer					
Colon polyps					
COPD (lung disease)					
Deep vein thrombosis					
Dementia					
Depression					
Diabetes					
Heart disease					
High cholesterol					
Hypertension					
Kidney disease					
Mental illness					
Osteoporosis					
Prostate cancer					
Pulmonary embolism					
Stroke					
Thyroid disease					
Other (list)					
Other (list)					
Other (list)					
Alive (Yes, No or N/A=Not Applicable)					

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Social History

Drugs and tobacco - Check one of the following about smoking tobacco:

☐Never smoked ☐Exposed to second hand smoke

☐Former smoker ☐Smoke some days ☐Smoke everyday

Lifestyle

On average, how many days per week do you engage in moderate to strenuous exercise?

☐1 day ☐2 days ☐3 days ☐4 days ☐5 days ☐6 days ☐7 days

On average, how many minutes do you engage in exercise at this level?

☐0 min ☐10 min ☐20 min ☐30 min ☐40 min ☐50 min ☐60 min ☐70 min

☐80 min ☐90 min ☐100 min ☐110 min ☐120 min ☐130 min ☐140 min ☐150+ min

Safety

Do you have a gun at home? ☐Yes ☐No

Do you use a bike helmet? ☐Yes ☐No

What is your current grade? _____

Additional comments:

Review of Systems – *Please circle which symptoms you have currently.*

General	fever decreased/no energy loss appetite unintended weight gain/loss	none
Head	headache injury	none
Eye	visual change crossed discharge redness puffiness	none
Ear	difficulty with hearing pain discharge	none
Nose	runny nose nasal congestion nose bleed	none
Mouth/throat	sore throat difficulty swallowing dental problems	none
Lung	shortness of breath coughing chest pain wheezing sputum blood in sputum	none
Heart	pale cyanosis chest pain leg swelling faint	none
Gastrointestinal	abdominal pain nausea vomiting diarrhea constipation distention blood in stool black/tarry stool	none
Genitourinary	painful urination urine retention incontinence difficulty urinating blood in urine	none
Musculoskeletal	deformities joint pain joint swelling difficulty in moving	none
Neurologic	dizziness weakness hand shakiness seizures	none
Skin	rash itching color change easy bruising/bleeding change in mole	none
Psychiatric	frequent mood change nervousness tension feeling down unable to sleep at night	none

_____ _____/_____/_____ (mm/dd/yyyy)

Printed name of person who completed this form Date

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