

Preferred Medical Group, PC

1200 W. 12 Mile Rd. Madison Heights, MI 48071

ADULT HEALTH INFORMATION FORM

Please do not stress over this form-do the best you can and we will do the rest!

Fax to 248.543.0562 or US mail when complete

(mw)

Identification

Name (Last)		(First)		(Middle Initial)	
Primary Address					
Date of Birth		Home Phone		Primary Doctor / PA	
City			State	Zip	
Cell Phone		Email Address			

Insurance Information OPTIONAL

Company Name	Identification-Group Number	Member(ID) Number
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Legal Documents/Medical Directives OPTIONAL

<input type="checkbox"/> Living Will <input type="checkbox"/> Durable Power of Attorney for Healthcare <input type="checkbox"/> Power of Attorney	Location of document (for example Bank of America)
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Medical and Surgical History (Check appropriate)

	Date of Onset		Date of Onset
<input type="checkbox"/> Acquired Immunodeficiency Syndrome (AIDS) or HIV Positive:		<input type="checkbox"/> Eye Problems	
<input type="checkbox"/> Allergic Rhinitis		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Alcohol (problems)		<input type="checkbox"/> Hypoglycemia	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Asthma		<input type="checkbox"/> High Cholesterol / Triglycerides	
<input type="checkbox"/> Bronchitis / COPD / Chronic Lung		<input type="checkbox"/> Mental Retardation	
<input type="checkbox"/> Cancer type:		<input type="checkbox"/> Depression	
<input type="checkbox"/> Colitis (Crohns, Ulcerative, other)		<input type="checkbox"/> Fibromyalgia	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Gout	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> GERD / Heartburn	
<input type="checkbox"/> Epilepsy / Seizures		<input type="checkbox"/> Heart Disease	

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<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Other Stomach /Intestinal Problems	
<input type="checkbox"/> Frequent Headaches /Migraines		<input type="checkbox"/> Syphilis	
<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Gonorrhea / Chlamydia		<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Hearing Impairment		<input type="checkbox"/> Urinary Tract Infection-many	
<input type="checkbox"/> Heart Condition		<input type="checkbox"/> Pneumonia Surgery #1	
<input type="checkbox"/> Herpes		<input type="checkbox"/> Other? Write in below if needed	
<input type="checkbox"/> High Blood Cholesterol		<input type="checkbox"/> Surgery #1	date
<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Surgery #2	date
<input type="checkbox"/> MRSA (Staph infection)		<input type="checkbox"/> Surgery #3	date
<input type="checkbox"/> Seizures		<input type="checkbox"/> Surgery #4	date
<input type="checkbox"/> Stroke		<input type="checkbox"/> Surgery #5	date

Immunizations OPTIONAL

Immunization for	Booster 1		Booster 2		Booster 3	
	Age	Date	Age	Date	Age	Date
Hepatitis A						
Hepatitis B						
Measles or Mumps or Rubella (circle)						
Pertussis/Whooping Cough (Adacel)						
Gardasil						
Tetanus (Td or dTAP)						

Allergies/Drug Sensitivities

Allergy/Sensitivity Type <i>(include medications foods environmental or other)</i>	Reaction	Date last Occurred	Treatment

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Family Member History **KEEP THIS SIMPLE—DON'T DO ANY RESEARCH HERE**

	Mother	Father	Sibling	Grandparent	Children
If deceased, indicate age of death					
Simply check all items that apply to any illnesses they have had					
Alcoholism					
Arthritis					
Asthma					
Cancer					
Diabetes					
Depression					
Emphysema					
Heart Condition					
High Blood Cholestrol					
High Blood Pressure					
Kidney Disease					
Seizures					
Stomach Liver or Intestinal Problems					
Stroke					
Thyroid Disorders					
Number of children, if any?					
Other					
Other					

Lifestyle

<input type="checkbox"/> Alcohol	Drink(s) Per Week _____	Number of Years _____
<input type="checkbox"/> Smoking	Pack(s) Per Day _____ Number of years _____	Quit? # of year ago _____
<input type="checkbox"/> Caffeine	Drinks / day _____	

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<input type="checkbox"/> Married/ Single/ Divorced <i>Circle please</i>	<input type="checkbox"/> Blood transfusion < 1991?	<input type="checkbox"/> Sex with Men /Woman /Both <i>Circle please</i>
<input type="checkbox"/> Occupation	<input type="checkbox"/> Substance Abuse?	<input type="checkbox"/>
<input type="checkbox"/> Exercise	Type(s) of Exercise	Days Per Week

Health Log Include ONLY major illness NOT captured above

Date Diagnosed	Doctor	Nature of Health Problems	Age at Onset	Condition Status	Remarks

Medications

Note: Include all prescription medications, (such as nitroglycerin) over-the-counter medications (taken on a regular basis), vitamin supplements, and herbal remedies

Medication	Dose	Medication	Dose	Medication	Dose

REVIEW OF SYSTEMS: (please circle any that you have had recently or chronically and add any other pertinent information)

GENERAL: fever, weight gain/loss, fatigue, other _____

EYES: vision loss, blurred, double, other _____

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EAR/NOSE/THROAT: pain, mass, bleeding, hearing loss, ringing in ears, other:

CARDIO: chest pain, shortness of breath on exertion, irregular heart rate, murmur, varicose veins, DVT, (clots), other:

REVIEW OF SYSTEMS continued:

LUNGS: short of breath, cough, asthma, COPD, bloody expectorant, other:

GASTRO: loss of appetite, swallowing problems, heartburn, persistent nausea / vomiting, ulcers, stomach pain, diarrhea, constipation, colitis, infectious diarrhea needing treatment, hemorrhoids, rectal bleeding, jaundice (yellow skin-eyes), other:

BLOOD: anemia, coagulation problems, clotting problems bleeding problems, blood cell problems, other, _____

URINARY / KIDNEY: frequent infections, blood in urine, kidney stones, frequent urination, loss of urine control, other: _____

MUSCLES/JOINTS: weak, arthritis pain, atrophy, severe injuries, surgeries, other:

SKIN: rash, dry, ulcers, psoriasis, fungus, cancers, other:

NEUROLOGIC: tingling, numbness, weak, moodiness, sadness, anxiety, panic, diagnosed diseases of the nerves, other:

Please add any other information you wish us to see: