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PATIENT INFORMATION
ADULT HISTORY

Please Print

TODAY'S DATE

NAME (LAST) FIRST	DATE OF BIRTH	SOCIAL SECURITY #	
ADDRESS (STREET)	CITY	STATE	ZIP
HOME PHONE#	WORK #	CELL #	E-MAIL
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ FEMALE ☐ MALE	EMERGENCY CONTACT PERSON	TELEPHONE #	
OCCUPATION	EMPLOYER		
IF NOT EMPLOYED, INDICATE SOURCE OF INCOME			
MICHIGAN DRIVER'S LICENSE	HOBBIES & INTERESTS	HOW DID YOU HEAR ABOUT US?	

HEALTH OF FAMILY

FAMILY MEMBER	GOOD	POOR	DIED	IF DIED, NOTE AGE AND CAUSE (INCLUDES FATAL ACCIDENTS AND SUICIDES)
FATHER (Natural, biological)				
MOTHER (Natural, biological)				
BROTHERS & SISTERS:				
SPOUSE				
CHILDREN				

IMMUNIZATIONS

CIRCLE THOSE YOU HAVE HAD AND ENTER THE YEAR OF THE MOST RECENT, IF KNOWN.

FLU _____ TETANUS _____ RUBELLA _____

MEDICINE ALLERGIES

LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

ILLNESS

IF YOU HAVE HAD ANY OF THE FOLLOWING, CHECK THE APPROPRIATE BOX ☐ . IF A BLOOD RELATIVE HAS HAD ANY OF THE FOLLOWING, CHECK THE APPROPRIATE CIRCLE ◯

☐ ◯ ALCOHOLISM	☐ ◯ EPILEPSY, SEIZURE	☐ ◯ CANCER, TUMOR
☐ ◯ ANEMIA	☐ ◯ GLAUCOMA	☐ ◯ HIGH BLOOD PRESSURE
☐ ◯ BLEED EASILY	☐ ◯ HEART DISEASE	☐ ◯ ULCER IN STOMACH OR DUODENUM
☐ ◯ DIABETES	☐ ◯ STROKE	
☐ ◯ DRUG ABUSE	☐ ◯ SUICIDE ATTEMPT	☐ ◯ NERVOUS BREAKDOWN

☐ DEPRESSION	☐ EYE PROBLEMS	☐ MUMPS, MEASLES, CHICKEN POX
☐ ECZEMA, HIVES, RASHES	☐ PHLEBITIS	
☐ LIVER DISEASE, HEPATITIS, YELLOW JAUNDICE	☐ THYROID DISEASE	☐ RUBELLA, GERMAN MEASLES
	☐ VENEREAL DISEASE	☐ RHEUMATIC FEVER
☐ LUNG DISEASE		

HOSPITALIZATIONS / SURGERY

LIST ILLNESS OR OPERATION, AND APPROXIMATE YEAR.

Year	Year
Year	Year
Year	Year

MEDICINES

LIST ALL MEDICINES, BIRTH CONTROL PILLS, OR VITAMINS YOU TAKE WITH OR WITHOUT A PRESCRIPTION:

CIRCLE ANY OF THE CONDITIONS, LISTED BELOW, THAT YOU HAVE EXPERIENCED.

1. **HEENT & M** - Headache Vision change & last test:_____ Hearing change Sinus congestion Swallowing Dental problems & last exam: _____
2. **NECK** - Swollen glands Stiff Pain
3. **RESPIRATORY** - Cough
4. **CARDIO/VASCULAR** - Chest pain / discomfort Racing heart High blood pressure Short of breath during sleep / exertion Swollen feet Varicose veins
5. **GI** - Nausea Vomiting Pain Stool black / blood Change in eating / bowel habits Bleeding
6. **GU** - Frequency Pain / burning Blood Stress / incontinence Stone Start / stop difficulty Prostate trouble Sex difficulty
7. **GYN** - Menarche at _____ LMP_____ Cycle _____ Flow _____ Abnormal Cramps Contraception_____ Hyst. / Menopause at_____ Abnormal Bleeding / Spotting Discharge Dysparunia Last pap / pelvic: _____
8. **BREAST** - Self exam Lump Pain Discharge
9. **OBSTETRICAL** - Pregnancies_____ Births_____ Prematures _____ Cesareans_____ Miscarriages_____ Abortions_____
10. **MUSCULO-SKELETAL** - Bone or joint Pain / swelling / deformity
11. **SKIN** - wart or mole change Skin problems
12. **NEUROLOGICAL** - Seizures Trembling Dizziness Memory Lose consciousness Behavior change
13. **MOOD** - Cry often Last time felt well:_____ Health worries Work / family problems Considered suicide
14. **LIFE STYLE** - Smoking Alcohol Drugs Sleep Exercise Meals Sexual dissatisfaction Appetite Weight change Job did / will change Seat belts Marital problems / changes Number of marriages_____ Family member: Illness, disability, social / emotional problem

Notes

I acknowledge that I have been offered the opportunity to read David B. Munro, M.D., P.C.'s Notice of Privacy and acknowledge the availability of a personal copy if I desire. Patient Financial Responsibility: I will provide all insurance cards . I authorize the release information needed to process any insurance claims. After 60 days, all charges, not paid by my insurance(s), are my responsibility. All co-pays and outstanding balances are to be paid before I see Dr. David B. Munro or Dr. Joshua D. Munro.

I hereby authorize the release of my medical information to _____ (circle relationship) Spouse Daughter Son Parent Other

SIGNATURE OF RESPONSIBLE PARTY X _____ DATE _____