24 HR Lifeline MD Urgent Care and Family Medicine
12640 Twelve Mile Rd, Warren, MI 48093
586-751-2020 Main
586-745-1756 Fax

PATIENT HISTORY

Patient Name Phone # Date

Address

Social Security# Birth Date

Transferring from:

Primary Family Physician _____

Address _____ Phone # _____

Occupation Retired ☐ Yes ☐ No

Employer Work Phone #

Employer's Address

Are you presently working? ☐ Yes ☐ No

Spouse's Name (ifmarried)

Spouse's Social Security # Birth Date:

Spouse's Employer Work Phone#

Employer's Address

PAST MEDICAL HISTORY

- ☐ Asthma
- ☐ Hypertension
- ☐ Stroke
- ☐ Menopause
- ☐ Atrial Fibrillation
- ☐ CAD/Panic
- ☐ CHF
- ☐ Depression
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Hypercholesterolemia
- ☐ Migraine Headache
- ☐ Blood Disorder
- ☐ Kidney Disease
- ☐ Osteoporosis Rheumatoid Gout
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Cancer
- ☐ Acne

Please list all past surgeries in chronologic order

Name of Surgery	Name of Surgeon / Hospital	Date of Surgery

MEDICA'I]IONS Please list all the medications you are currently taking including vitamins, nutritional supplements, herbal remedies and over the counter medications.

Name of Medication	Dosage or Strength	How Often Each Day

ALLERGIES Please list allergies to ll medication, foods, dyes or materials.

List of drugs and type of reaction

_____

_____

_____

_____

_____

_____

_____

REVIEW QF SYSTEMS Are you c rrently experiencing any of the follhwin ?

Constitutional	Fever	D Yes	D No	**GUI**	Urinary Urgency	D Yes	D No
	Weight Loss	D Yes	D No		Incontinence	☐ Yes	☐ No
	Weight Gain	☐ **Yes**	☐ No		Sexual Difficulty	☐ Yes	☐ No
Eyes	Blurred Vision	☐ Yes	☐ No	**Muscular/**	Joint Pain	☐ Yes	☐ No
	Double Vision	☐ Yes	D No	**Skeletal**	Back Pain	☐ Yes	☐ No
	Wear Glasses	☐ Yes	D No		Neck Pain	☐ Yes	☐ No
ENT	Hearing Loss	☐ Yes	☐ No	**Skin**	Rashes	☐ Yes	☐ No
	Sinusitis	☐ Yes	☐ No		Bruising	☐ Yes	☐ No
	Neck Swelling	☐ Yes	☐ No		Keloids	☐ Yes	☐ No
CVS	Chest Pain	☐ Yes	D No	**Neurological**	Stroke	☐ Yes	D No
	Palpitation	☐ Yes	D No		Seizures	☐ Yes	☐ No
	Heart Attack	☐ Yes	☐ No		Headaches	D Yes	☐ No
					Paralysis	☐ Yes	☐ No
GI	Constipation	☐ Yes	☐ No		Weakness	☐ Yes	☐ No
	Fecal Incontinence	☐ Yes	☐ No		Where? _____		
	Jaundice	D Yes	D No		Numbness	☐ Yes	☐ No
					Where? _____		
Respiratory	Shortness of Breath	☐ Yes	☐ No	**Psychiatric**	Depression	☐ Yes	☐ No
	Wheezing	☐ Yes	☐ No		Other Psychiatric illness	☐ Yes	☐ No
	Coughing	D Yes	☐ No				
	Asthma	D Yes	☐ No	**Blood Disorder** (easy bruising, thin blood)		D Yes	☐ No

Are you ☐ Right handed ☐ Left handed

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have any children? ☐ Yes ☐ No If so, how many?

Do you smoke? ☐ Yes ☐ No If so, how many packs and how long?

Do you drink? ☐ Yes ☐ No If so, how many per day?

Do you use drugs? ☐ Yes ☐ No If so, type and how often?

Gender ☐ Mr ☐ Mrs ☐ He ☐ She ☐ Him ☐ Hers ☐ LGBTQ

FAMILY HEALTH HISTORY

☐ **High Blood Pressure**
☐ **Stroke**
☐ **Diabetes**
☐ **Heart Disease**
☐ **Heart Attack**
☐ **Cancer**
☐ **Seizures**
☐ **Psychiatric/Emotional Problems**

	IF LIVING		*IF DECEASED*	
Relationship	*Age*	*Health Problems*	*Age at Death*	*Cause o fDeath*
Father				
Mother				
Sister/Brother				
Sister /Brother				
Grandparents				
Grandparents				
Children				
Other				
Other				

Patient Signature Date _____

Physician Signature Date _____