Steven Margolis, MD
Christina Munn, PA-C
Bethany Morrell, PA-C
Brittany Sharp, FNP-BC

43956 Mound Rd.
Sterling Heights, MI 48314
(586) 838-2464
Fax (586) 221-4614

Complete Family Care

This information is very important to your health. Please take time to full & accurately fill out this form.

Name: _____ Date: ___ / ___ / _____ Doctor: _____
Birthday: ___ / ___ / _____ Reason for Visit: _____
Date of Last Physical: ___ / ___ / _____ Place Examined: _____
Did someone refer you to our office? If yes, who? : _____

Medication:
Do you take any medicines (including birth control, supplements, vitamins, etc.)? If yes, what and how much? _____
_____
Known drug allergies? If yes, what type and reaction? _____

Social History (if yes, please list details):
What type of work do you do or have you done? _____
Have you been exposed to any hazardous materials? _____
What do you do for recreation, entertainment, fun? _____
Have you travelled outside the US/Canada? _____
What do you do for exercise? _____
Do you have a special diet or food intolerances/allergies? _____
Are you happy with your life? _____ Do you sleep well? _____
Do you feel that there is significant stress in your life? _____
Marital Status (circle one): Single Married Separated Divorced Widowed Never Married Domestic Partner Not Provided
Last Grade Completed (circle/list): 8 9 10 11 12 Associates Bachelors Masters Other: _____
Have you ever been rejected for health reasons by the military, an employer, or an insurance company?
Were you sick, but failed to get medical attention in the last year?
Did you miss more than 10 days of your usual activities within the last year due to illness?

Immunizations (list month/year if known):
DTP/DtaP: _____ Seasonal Flu Shot: _____ Meningococcal: _____ MMR (Measles/Mumps/Rubella): _____
Varicella (Chicken Pox): _____ Hepatitis B: _____ T.B. (Tuberculin Test): _____ Polio (Type IPV/OPV): _____
Other(s): _____

Hospitalizations/Surgeries:
Please list approximate date, reason for, hospital and surgeon(if applicable, please begin with the most recent): _____
_____

Health/Family History:

FEMALES:			MALES:		
Birth control use	YES	NO	Lump or swelling of testicles	YES	NO
Breast lump or disease	YES	NO	Testicular Pain	YES	NO
Pregnancy problems	YES	NO	Discharge from penis	YES	NO
Vaginal infections	YES	NO	Prostate problems	YES	NO
Irregular periods	YES	NO			

Have you ever had any serious illness? _____

Have you ever had a hernia? _____

	Name	Birth Year	Death Year	State of Health (including health problems and cause of death)
Father :				
Mother:				
Sibling :				
Sibling :				
Sibling :				
Sibling :				
Sibling :				
Sibling :				
Spouse:				
Child :				
Child :				
Child :				
Child :				

Do you or any of your family members have (or previously had):

	YOU	RELATIVE		YOU	RELATIVE
Typhoid fever/Whooping cough			Stroke		
Mumps, measles, chicken pox			Glaucoma		
Scarlet fever, rheumatic fever			Epilepsy		
German measles			Tuberculosis		
Heart Disease/Murmur			Lung Disease		
Kidney/Bladder Problems			Arthritis		
Cancer/Tumor			Asthma		
Bleeding problem			Alcoholism		
Depression			Allergies		
Suicide attempt			Gout		
Nervous breakdown			Phlebitis		
Liver disease			Anemia		
Thyroid disease			Diabetes		
Back problems			Tobacco use		
Drug abuse			Venereal disease		
High blood pressure			Sexual difficulty		
Hepatitis			Other _____		
Jaundice					
Pleurisy/Pneumonia					

SIGNATURE: _____

Today's Date: _____ / _____ / _____