WESTERN MICHIGAN UNIVERSITY
Homer Stryker M.D.
SCHOOL OF MEDICINE

ADULT HEALTH HISTORY

(Please complete in ink)

Today's Date: ______________________ **MRN:** ____________________ **Date of Birth:** ___________________

Last Name:		First :		Middle:
Sex:		Race:		
Marital Status (Please Circle): Married	Single	Divorced	Partnered	Widow/Widower
What is highest level of education attained:		Grade School	High School	College
Occupation:				
What is the primary language of your household?				
Do you have an Advanced Directive at WMU School of Medicine? Yes No				
Do you have a durable power of attorney for medical care? Yes No If Yes, Name: Phone:				

MEDICAL HISTORY:

List your **medical problems**:

____

____

____

____

SURGICAL HISTORY:

List your **surgical procedures:**

____

____

____

Name of previous physician(s): ____

Name of primary care physician: ____

Name of specialty physician(s): ____

MEDICATIONS:

List all medications you are taking; including vitamins, herbal preparations and over the counter medications.

Name of Medication:	Dosage of Medication:	How often you take the medication/what time of day you take the medication?

Original Effective Date: 07/25/03
Revised Date: 06/16/10
07/12/10

Name: ________________________________ **MRN:** __________________ **Date of Birth:** ___________________

Allergies and reactions to drug, food or environment (please list):

FAMILY HISTORY:

Please tell us about the **health** of your **parents** and brothers and/or sisters:

Father: ____

Mother: ____

Brothers: ____

Sisters: ____

Children: ____

Other family history of note (grandparents):____

PSYCHOSOCIAL:

Do you use tobacco currently? Yes No If yes, for how long? How many packs/day? Have you used tobacco in the past? Yes No If yes, for how long? How many packs/day?
Do you drink alcoholic beverages? Yes No Do you drink caffeinated beverages? Yes No
Do you use recreational drugs? Yes No
Do you exercise? Yes No Type of exercise: How often: Daily Weekly Monthly Other
Has there ever been any domestic violence or incidents of physical, verbal or sexual abuse in your household? Yes No If yes, please explain:
Are there any community agencies assisting you? Yes No Please state contact person:
Do you have any special needs?
Do you have any cultural, religious or spiritual beliefs that affect the decisions you make about your medical care? Yes No If yes, please explain:
Are you currently having thoughts of harming yourself or others? Yes No

FUNCTIONAL:

Do you have any recent changes in your mobility, use and function of arms or legs? Yes No Any difficulty performing daily activities or problems speaking or swallowing? Yes No Have there been any changes in your eating habits? Yes No If yes to any of the above, please explain:
Are you on a special diet? Yes No If yes, please explain: Have you had any recent changes in your weight? Yes No If yes, please explain:

Name of person completing form/relationship to patient (please print): **Signature:**

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