



Partners In Internal Medicine

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734 981-3300

PATIENT HISTORY

IF YOU CAN READ THIS FORM, PLEASE SIGN HERE: _____

Name: _____ Date of Birth: _____
Occupation: _____ Type of Work: _____

Family Medical History

Please check if any blood relative now has or has had any of the following conditions:

<u>Condition:</u>	<u>Relation:</u>	<u>Condition:</u>	<u>Relation:</u>
<input type="checkbox"/> Cancer - Type	_____	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Depression / Att. Suicide	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Bleeding Problems	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Other Illness:	_____

Your Medical History:

Prior Surgery

<u>Operation</u>	<u>Year</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical Illnesses / Injuries

<u>Condition</u>	<u>Year</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all Medications You Take:

(including over-the-counter)

<u>Medication</u>	<u>Dose</u>	<u>Times per Day</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies:

<u>Medication</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

