Professional Village Medical Center
13700 19 Mile Road, Sterling Heights, MI 48313
Phone: (586) 247-6020 eFax: (586) 737-2338

Please read and complete ALL of the following information - Thank you!

Health History Information

Today's Date:

Full Name:	Date of Birth:	Primary Language:

Race:				
	American Indian / Alaskan Native	Black / African-American	White	Asian
	Native Hawaiian / Other Pacific Islander	Multiple Races	Unknown	Refuse to Answer

Ethnicity:			
Hispanic (or Latino)	Non-Hispanic	Unknown	Refuse to Answer

Pharmacy Information

Name of Local Pharmacy:	Approximate Location of Pharmacy & Phone Number:
Name of Mail Away Pharmacy (if applicable):	Address of Mail Away Pharmacy & Phone Number:

Allergies

Please list allergen along with what type of reaction occurs

Medication Allergies:	Food Allergies:
Contactant Allergies:	Environmental Allergies

Immunizations

Please answer all below to the best of your knowledge. If you have an existing record, please provide to us.

Name of Vaccine	Did you have?	If yes, when and where?
Pneumovax 23 (pneumonia vaccination)	Yes / No / Unsure	
Prevnar 13 (pneumonia vaccination)	Yes / No / Unsure	
Zostavax (shingles vaccination)	Yes / No / Unsure	
Td (Tetanus vaccination)	Yes / No / Unsure	
Tdap (Tetanus with pertussis vaccination)	Yes / No / Unsure	
Seasonal Influenza vaccination	Yes / No / Unsure	
Are you up to date with all other vaccinations?	Yes / No / Unsure	

Personal Medical History

Please answer all below based on your own, personal health history

Do you have, or have you had…

Cancer?	Yes / No	If yes, what kind?
Diabetes?	Yes / No	If yes, what kind?
Thyroid Disease?	Yes / No	If yes, what kind?
Stroke?	Yes / No	If yes, when?
Heart Disease?	Yes / No	
Heart Attack?	Yes / No	If yes, when?
Heart By-Pass/Stent?	Yes / No	If yes, when?
High Cholesterol?	Yes / No	
High Blood Pressure?	Yes / No	
Asthma?	Yes / No	
Anemia?	Yes / No	
COPD?	Yes / No	

Please list any other past medical conditions not mentioned above:

Family Medical History

Please answer all below based on your relatives' (parents, grandparents, siblings, children) health history

Are you adopted? Yes / No	Is your family medical history unknown? Yes / No

Does a relative have, or have they had… **indicate if maternal or paternal relative**

Cancer?	Yes / No	If yes, who & what kind?
High Cholesterol?	Yes / No	If yes, who?
Diabetes?	Yes / No	If yes, who & what kind?
Heart Disease?	Yes / No	If yes, who?
Heart Attack?	Yes / No	If yes, who?
Heart By-Pass/Stent?	Yes / No	If yes, who?
Stroke?	Yes / No	If yes, who?
Thyroid Disease?	Yes / No	If yes, who & what kind?
High Blood Pressure?	Yes / No	If yes, who?

Please list any other family medical history & conditions not mentioned above:

Social History

Do you exercise regularly?	Yes / No	If yes, how often and what form?	
Do you use any illicit drugs?	Yes / No	If yes, what kind and how often?	
Do you drink alcohol?	Yes / No	If yes, what kind, how often, and how much?	
Do you drink caffeine?	Yes / No	If yes, what is it and how many cups do you consume in a day?	
Do you use any tobacco? (this includes smokeless tobacco & "vaping")	Yes / No	If yes, what kind, how often, and how much?	
If you are a current smoker, how long have you been smoking?		If you are NOT a current smoker, are you regularly exposed to tobacco smoke?	
Are you a former tobacco user/smoker?	Yes / No	If yes, how many years did you smoke?	When did you quit?

Travel History

Have you travelled outside of the country in the last 6 months?	Yes / No	If yes, where?

Surgical History

Please list all previous surgical procedures & approximate dates:

Pregnancy/Birth History (females only)

Number of pregnancies:	Number of live births:

Diagnostic Studies / Health Maintenance

Please list all previous exam dates below (if able, please provide a copy to the office)

Last Complete Physical:	Last Colonoscopy:	Last Bone Density:
Last Stress Test:	Last Mammogram:	Last Pap Smear:
Last Dental Exam:	How often do you get dental examinations?	
Last Eye Exam:	How often do you get eye examinations?	

Medications / Supplements

Please list any current medications being taken, including all over-the-counter products and supplements. Please list what the dosage is and how often you take it. If the prescription is managed by another physician, please list who that physician is.

Medication/Supplement	Dosage	Frequency	Prescribing Physician