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

New Patient-Child / Medical History

Name: ______________________ Date: ___/___/___ Doctor: ______________________

Birth date: ___/___/_____ Guardian's Name: ______________________ Relation: ______________________

Reason for visit: ____

Last date of doctor visit: ___/___/_____ Place examined: ______________________

Medication: Do you take any medicines (including non-prescription drugs like aspirin and vitamins)? If yes, what and how much? ______________________

____

____

Are you allergic to any medications? If yes, which ones and what type of reaction do you have?

____

____

Social History:

What do you do for recreation, entertainment, fun? ______________________

Are you active? Yes No If yes, about how many hours during the day? ______

What do you do for exercise? ______________________

Do you sleep well? Yes No Do you have a special diet? Yes No

Last grade completed in school: ______________________

Did you miss more than ten days of your usual activity within the last year due to illness? Yes No

If yes, explain… ______________________

Do you have trouble seeing? Yes No Last eye exam date: ____/____/________

Do you have hearing problems? Yes No Behavioral issues? Yes No

Problems concentrating? Yes No Learning Disabilities? Yes No

Immunizations: Have you received…?

Year	Year	Year
Tetanus: ______________	Pneumovax: ______________	Rubella: ______________
Flu shot: ______________	TB test: Positive Negative	MMR: ______________
Varicella: ______________	Hepatitis B series: _______ _______ _______	

O V E R

Hospitalizations: Have you ever been hospitalized? Begin with most recent:

Date:	Operation or Illness:	Hospital:	Physician:

Family History:

	Name	Yr. of birth	Age, if Living	Age at Death	State of health (including health problems) or cause of death:
Father					
Mother					
Brothers and Sisters					

Do you or any of your family members have (or had): (please ✓ if you have, × if you had, or list relative)

	You	Relative		You	Relative
Allergies			Asthma		
Typhoid fever/ Whooping cough			Diabetes		
Mumps, measles, chicken pox			Frequent colds		
Frequent ear infections			Throat infections		
Tonsillitis			Anemia		
Scarlet fever, rheumatic fever			Epilepsy		
German measles/ measles			Tuberculosis		
Heart disease/ Murmur			Lung Disease		
Kidney/ Bladder problems			Cancer/ Tumor		
Bleeding problem			Liver disease		
High blood pressure			Thyroid disease		
Hepatitis			Other:		
Pleurisy/ pneumonia					

Have you ever had a serious illness or injury not listed above? If so, what? __________

Guardian's Signature: ____________________ **Date:** ___/___/____