Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Adult Medical History

Instructions: Please fill out as completely as possible. All information will be kept confidential

BCN OF MICHIGAN MEMBER NUMBER	DATE

PATIENT IDENTIFICATION INFORMATION

NAME – LAST	FIRST	MIDDLE	DATE OF BIRTH	AGE	SEX ☐ M ☐ F
ADDRESS – NUMBER & STREET	CITY	STATE	ZIP	HOME PHONE ( )	
OCCUPATION	EMPLOYER NAME			BUSINESS PHONE ( )	
EMPLOYER ADDRESS	CITY			STATE	ZIP
EMERGENCY CONTACT PERSON	NAME	RELATIONSHIP		HOME PHONE ( )	
ADDRESS	CITY	STATE	ZIP	WORK PHONE ( )	

CURRENT MEDICAL PROBLEMS

If you are being treated for any other illnesses or medical problems by another physician, please describe the problems and indicate the name of the physician treating you.

ILLNESS OR MEDICAL PROBLEM	PHYSICIAN TREATING YOU

ILLNESSES AND MEDICAL PROBLEMS

Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when each started. If you are not certain when an illness started, write down an approximate year.

ILLNESS	X	YEAR	ILLNESS	X	YEAR	ILLNESS	X	YEAR
Eye or eye lid infection	☐	______	Other heart condition	☐	______	Head injury	☐	______
Glaucoma	☐	______	Stomach/duodenal ulcer	☐	______	Stroke	☐	______
Other eye problems	☐	______	Diverticulosis	☐	______	Convulsions, seizures	☐	______
Deafness	☐	______	Colitis	☐	______	Arthritis	☐	______
Bronchitis	☐	______	Gout	☐	______	Cancer or tumor	☐	______
Emphysema	☐	______	Yellow jaundice	☐	______	Bleeding tendency	☐	______
Pneumonia	☐	______	Liver trouble	☐	______	Diabetes	☐	______
Allergies or asthma	☐	______	Hepatitis	☐	______	Psoriasis	☐	______
Tuberculosis	☐	______	Hernia	☐	______	Mental Illness	☐	______
Other lung problems	☐	______	Hemorrhoids	☐	______	Fibroids	☐	______
High Blood Pressure	☐	______	Kidney or bladder disease	☐	______	Other	☐	______
Heart attack	☐	______	Kidney Stone	☐	______			
High cholesterol	☐	______	Prostate problem	☐	______			
Arteriosclerosis	☐	______	Migraine headaches	☐	______			
Heart murmur	☐	______	Epilepsy	☐	______			

HOSPITALIZATIONS

Please list if any, that you have been hospitalized. Don't include normal pregnancies.

YEAR	OPERATION OR ILLNESS	HOSPITAL AND CITY

MEDICATIONS

Please list all medication you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets, vitamins, minerals and supplements).

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

ALLERGIES AND SENSITIVITIES

List anything that you are allergic to, such as certain foods, medications, dust, chemicals or soaps, household items, pollen, bee stings, etc., and indicate how each affects you.

1.	5.
2.	6.
3.	7.
4.	8.

SOCIAL / PERSONAL HISTORY

CURRENTLY LIVE: ☐ ALONE ☐ WITH FAMILY ☐ ALONE ☐ WITH FRIENDS ☐ WITH SIGNIFICANT OTHER

MARITAL STATUS: ▶ ☐ MARRIED ☐ DIVORCED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED

LAST GRADE COMPLETED IN SCHOOL

HAVE YOU EVER BEEN REJECTED FOR HEALTH REASONS BY THE MILITARY, AN EMPLOYER, OR AN INSURANCE COMPANY

☐ YES ☐ NO IF YES, EXPLAIN:

WERE YOU SICK, BUT FAILED TO GET MEDICAL CARE IN THE LAST YEAR?

☐ YES ☐ NO

DID YOU MISS MORE THAN TEN DAYS OF YOUR USUAL ACTIVITY LAST YEAR DUE TO ILLNESS?

☐ YES ☐ NO

SMOKING HISTORY ▶	DO YOU CURRENTLY SMOKE?	HOW MUCH PER DAY?	HOW MANY YEARS?	ARE YOU A FORMER SMOKER?	DO YOU CHEW TOBACCO?
	☐ YES ☐ NO			☐ YES ☐ NO	☐ YES ☐ NO

CONSUMPTION OF ALCOHOLIC BEVERAGES

☐ YES ☐ NO AMOUNT____________

DO YOU USE DRUGS?

☐ YES ☐ NO TYPE:____ FREQUENCY:____________________________

DO YOU EXERCISE REGULARLY?

☐ YES ☐ NO HOW OFTEN____________________

DO YOU WEAR SEATBELTS?

☐ YES ☐ NO

Are there any health risks involved in your job, home environment, or activities? ☐ YES ☐ NO If yes, explain

FAMILY HEALTH

Please give the following information about your immediate family:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
SPOUSE			
CHILDREN			

Have any blood relatives had any of the following illnesses?
If so, indicate relationship by placing an X in the appropriate box.

ILLNESS	FATHER	MOTHER	BROTHER	SISTER
HEART DISEASE				
HIGH BLOOD PRESSURE				
CANCER				
DIABETES				
BLOOD DISEASE				
EPILEPSY				
RHEUMATOID ARTHRITIS				
GOUT				
GLAUCOMA				
TUBERCULOSIS				

SYSTEM REVIEW

Place a mark in the box for each item that you have now or have had in the past and where applicable, please fill in additional information.

GENERAL ▶	☐ weakness ☐ chills ☐ fatigue ☐ night sweats	☐ change in weight, appetite or sleeping habits	
SKIN ▶	☐ itching ☐ rash	☐ change in color	☐ easy bruising
NERVOUS SYSTEM ▶	☐ headache ☐ dizziness	☐ double vision ☐ muscle weakness	☐ numbness ☐ loss of coordination
LUNGS ▶	☐ cough ☐ wheezing	☐ shortness of breath ☐ spitting up blood	☐ positive TB test ☐ last chest x-ray date:__
HEART ▶	☐ chest pain ☐ palpitations (heart pounding)	☐ trouble breathing at night ☐ trouble climbing stairs	☐ easy fatigue ☐ ankle swelling
GASTROINTESTINAL ▶	☐ stomach pain/abdominal pain ☐ indigestion/heart burn	☐ difficulty swallowing ☐ vomiting	☐ changes in bowel habits ☐ blood in stools
URINARY ▶	☐ pain on urination ☐ blood in urine	☐ frequent urination ☐ previous infections	☐ difficulty starting to urinate
EYES ▶	☐ glasses/contacts ☐ eye pain	☐ excessive tearing ☐ blurring or spots	☐ last eye exam date:______
EARS ▶	☐ loss of decreased hearing	☐ ringing	☐ drainage
NOSE / THROAT / SINUSES ▶	☐ nosebleed ☐ sore throat	☐ hoarseness ☐ post nasal drip	☐ swelling
MOUTH ▶	☐ dentures ☐ bleeding gums	☐ toothache	☐ last dental exam:_____________
JOINTS & BACK ▶	☐ pain ☐ swelling	☐ stiffness	☐ deformity
MUSCLES ▶	☐ pain ☐ weakness	☐ twitching	
ENDOCRINE ▶	☐ excessively hot ☐ excessively cold	☐ always thirsty ☐ always hungry	
PSYCHOLOGICAL ▶	☐ nervousness ☐ depression	☐ unable to sleep ☐ nightmares	☐ memory loss
IMMUNIZATIONS ▶	☐ Tetanus date:______________________ ☐ German Measles date:_______________		☐ Influenza date:__________________ ☐ Pneumococcal date:_______________
MALE ▶	☐ hernia ☐ discharge from penis	☐ pain in testicles ☐ sexually transmitted disease	☐ sexual difficulties
FEMALE ▶	☐ vaginal itching or burning ☐ vaginal discharge ☐ problem with menstrual periods ☐ last menstrual period date:_____________ ☐ last Pap smear date:________________ ☐ methods of contraception_____________ ☐ sexually transmitted disease ☐ sexually difficulties	☐ pregnancy, number:_________ ☐ miscarriages or abortions, number:_________ ☐ live births, number:__________________ ☐ problems during pregnancy ☐ lumps in breast ☐ discharge from nipple ☐ last mammography date _________________	

SIGNS & SYMPTOMS NOT COVERED (additional space on back)

MEMBER SIGNATURE	DATE
PHYSICIAN SIGNATURE	DATE

LIST ANY QUESTIONS OR CONCERNS YOU MAY HAVE FOR YOUR PHYSICIAN