The Office of Dr. Sherri L. Graf, D.O. and Dr. Ebonie Z. Harris, M.D.
29877 Telegraph Road, Suite 210
Southfield, MI 48034
(p) 248.223.9202

Patient Self-History Form

Date ______________________________

Patient Name ______________________________

Birth Date ______________________ Soc. Sec. No. ______________________

Marital Status: S M D W

Phone: ( ) ______________________ Work Phone: ( ) ______________________

Address ______________________________

City/State/Zip ______________________________

Emergency Contact (Name & Phone) ______________________________

Previous Physician's Name and Address: ______________________________

____

Have you ever had a MAMMOGRAM? ☐ Yes ☐ No If yes, when? ______________

Date of last Pap Smear ______________ Date of last menstrual period ______________

Age at first period ______________ How heavy is your flow? ______________

How many days from the beginning of one period to the next? ______________

Do you have discomfort with your periods? ☐ Yes ☐ No If yes, explain: ______________

____

Do you take medication or do anything for the discomfort? ☐ Yes ☐ No If yes, what ______________

____

Are you allergic to any medications? ☐ Yes ☐ No Penicillin __________ Codeine __________

Iodine __________ Tape __________ Other __________

List all medications that you are presently taking ______________________________

____

Are you sexually active? ☐ Yes ☐ No Do you have pain with intercourse? ☐ Yes ☐ No

What is your present method of birth control? ______________________________

Total pregnancies: Full Term __________ Pre-Term __________ Miscarriages __________

Abortions __________ Living Children __________ Adopted Children __________

Do you wear glasses? ☐ Yes ☐ No Contact Lenses? ☐ Yes ☐ No Other __________

Have you ever had surgery? ☐ Yes ☐ No If yes, what and when? Explain ______________

____

Have you ever been in any major accidents? ☐ Yes ☐ No If yes, explain ______________

____

Do you have or has anyone in your family had any of the following: Check all that apply.

If so, please write in who has/had the condition:

Heart disease or murmur ______	Kidney/Liver disease ______
High Blood Pressure ______	Hepatitis ______
Migraine Headaches ______	Blood Clots ______
Cancer ______	Constipation ______
Breast Cancer ______	Ulcers ______
Lung Problems ______	Thyroid Condition ______
Tuberculosis ______	Severe Depression ______
Pneumonia ______	Suicidal Thoughts ______
Asthma ______	Nervous Condition ______
Epilepsy ______	Arthritis ______
Stroke ______	High Cholesterol ______
Endometriosis ______	Fibroids ______
Diabetes ______	

Do YOU have or have YOU had any of the following: Check all that apply.

Anemia (Low Blood Count) ______	HIV ______
Blood Transfusions ______	Herpes ______
Urinary Tract/Bladder Infection ______	Syphilis ______
Hemorrhoids ______	Gonorrhea ______
Infertility ______	Chlamydia ______
Painful Periods ______	Crabs ______
Pelvic Infections ______	Trichomoniasis ______
Abnormal Bleeding ______	Genital Warts ______

Do you smoke? ☐ Yes ☐ No If yes, how much? ______ How long? ______

Do you drink coffee/tea? ☐ Yes ☐ No If yes, how much per day? ______

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per day? ______

Do you drink cola? ☐ Yes ☐ No If yes, how much per day? ______

Have you ever used marijuana? ☐ Yes ☐ No Cocaine? ☐ Yes ☐ No Heroine? ☐ Yes ☐ No

Other? ______

Thank you very much for taking the time to complete this questionnaire. The answers you have provided will help us further plan your care. If you feel there is anything else we need to know about you, you can write it below in the space provided or wait and discuss it with the Doctor on your first visit.

______

______

______

______