Medical History Form

Date: _____

Name _____

Date of Birth: _____ Age _____ Gender _____

Phone _____ Email _____

Allergies _____

How did you hear about the Infusion Center/Services? _____

Referring Provider: _____ Phone _____

Primary Care Provider: _____ Phone_____

Mental Health Providers:_____ Phone_____

ALLERGIES

PAST MEDICAL HISTORY

Do you have any of these conditions? *Check appropriate box and provide date of onset*

☐ = *Past Condition* ☐ = *Current Condition*

NEUROLOGIC / MOOD

☐ ☐ Depression _____
☐ ☐ Anxiety _____
☐ ☐ PTSD _____
☐ ☐ Insomnia _____
☐ ☐ Schizophrenia _____
☐ ☐ Hallucinations _____
☐ ☐ ADD/ADHD _____
☐ ☐ Suicidal _____

☐ ☐ History of Mental Health Crises _____
☐ ☐ Seizures _____
☐ ☐ Stroke _____
☐ ☐ Neuromuscular Disease _____
☐ ☐ History of Psychiatric Admission _____
☐ ☐ Other _____

METABOLIC / ENDOCRINE

☐ ☐ Hypothyroid (underactive) _____
☐ ☐ Hyperthyroidism (overactive thyroid) _____
☐ ☐ Other _____

RESPIRATORY

☐ ☐ Shortness of Breath _____
☐ ☐ Asthma _____
☐ ☐ Obstructive Sleep Apnea _____
☐ ☐ Pulmonary Hypertension _____
☐ ☐ Other Lung Disorders _____

GU /GI

☐ ☐ Kidney Disease _____
☐ ☐ Liver Disease _____
☐ ☐ Other _____

CARDIOVASCULAR

☐ ☐ High Blood Pressure Controlled / Uncontrolled _____
☐ ☐ Chest Pain _____
☐ ☐ Heart Murmur _____
☐ ☐ Heart _____
☐ ☐ Valve Disease _____
☐ ☐ Heart Failure _____
☐ ☐ Abnormal Heart Rhythm _____
☐ ☐ Bleeding Disorder _____
☐ ☐ Other _____

PAIN

☐ ☐ Acute Pain _____

☐ ☐ Chronic Pain _____

☐ ☐ Fibromyalgia _____

☐ ☐ Other _____

INFECTIOUS

☐ ☐ HIV _____

☐ ☐ Tuberculosis _____

☐ ☐ Hepatitis _____

☐ ☐ Other _____

HEMATOLOGY / ONCOLOGY

☐ ☐ Bleeding Disorder _____

☐ ☐ Cancer (explain) _____

☐ ☐ Other _____

OTHER

☐ ☐ Substance Abuse (please circle)

Marijuana _____ Frequency_____ Last used _____
Cocaine _____ Frequency_____ Last used _____
Methamphetamine __ Frequency_____ Last used _____
Heroin_____ Frequency_____ Last used _____
Ketamine_____ Frequency_____ Last used _____
Other Recreational substances _____
_____ Frequency_____ Last used _____

☐ ☐ History of assault _____

☐ ☐ History of violent behavior _____

☐ ☐ Other _____

PAST SURGICAL HISTORY ☐ None

_____
_____
_____
_____
_____
_____
_____
_____
_____

CURRENT MEDICATIONS / SUPPLEMENTS ☐ None

NAME / DOSE	Reason For Use

I am currently compliant with all medications prescribed by my mental health provider

☐Yes ☐No If no, please explain:

Other Important Information:

Patient Signature _____Date _____Time _____