MEDICAL AND HEALTH HISTORY

Date ______________ Patient Name ____ Date of Birth _____________

MAIN PROBLEM

What is the reason for your visit today? ____

What happened RECENTLY to make you decide to seek help now? ____

____

What would you like this clinic to do for you? ____

PATIENT HISTORY

Have you ever had any of the following (P=In the past, C=Currently under treatment for)?

P	C		P	C		P	C		P	C	
☐	☐	AIDS or HIV	☐	☐	dizziness	☐	☐	IBS/irritable bowel	☐	☐	speech problems
☐	☐	allergies	☐	☐	eating problems	☐	☐	kidney problems	☐	☐	stomach problems
☐	☐	anemia	☐	☐	epilepsy or seizures	☐	☐	liver problems	☐	☐	stroke or TIAs
☐	☐	anorexia	☐	☐	fibromyalgia/chronic fatigue	☐	☐	Lupus	☐	☐	tension headaches
☐	☐	arthritis	☐	☐	frequent neck/shoulder pain	☐	☐	menstrual problems	☐	☐	thyroid problems
☐	☐	asthma	☐	☐	GI difficulties	☐	☐	migraines/severe headaches	☐	☐	tuberculosis
☐	☐	blackouts/memory loss	☐	☐	head injury	☐	☐	MS	☐	☐	ulcers
☐	☐	cancer	☐	☐	hearing problems	☐	☐	paralysis	☐	☐	vision problem
☐	☐	chronic pain	☐	☐	heart attack/disease	☐	☐	physical abuse	☐	☐	weight gain
☐	☐	circulation problems	☐	☐	hepatitis	☐	☐	sexual abuse	☐	☐	weight loss
☐	☐	coronary problems	☐	☐	high/low blood pressure	☐	☐	sexual problems			other, please list: ______
☐	☐	depression	☐	☐	high cholesterol	☐	☐	skin problems			____________________
☐	☐	diabetes	☐	☐	hypoglycemia	☐	☐	sleep problems			

CHECK **any** of the following that apply to you **now or within the past month**:

			Loss of control in the following:
☐ crying spells	☐ seeing things others don't	☐ racing thoughts	☐ alcohol/drug use
☐ feeling hopeless	☐ unusual thoughts	☐ fear of dying	☐ overeating/bingeing
☐ relationship breakup	☐ increased alcohol or drug use	☐ job stress	☐ purging
☐ loneliness/emptiness	☐ withdrawal symptoms	☐ decreased activity	☐ yelling/breaking things
☐ loss of appetite	☐ financial worries	☐ not seeing friends	☐ hitting people
☐ nightmares	☐ nervous/anxious	☐ feel controlled	☐ spending
☐ thoughts of harming self	☐ panic attacks	☐ feel talked about	☐ gambling
☐ thoughts of harming others	☐ can't concentrate	☐ guilt/shame	
☐ suicide attempts	☐ confusion	☐ school problems	
☐ hearing voices	☐ mood swings		

Please explain checked items: ____

____

DEVELOPMENTAL:

Developmental Delays:____

Hyperactivity/ADHD? ☐ Yes ☐ No   Seizures as a child? ☐ Yes ☐ No

MEDICATIONS:

List any prescription and non-prescription medications taken regularly (include over the counter, herbal, vitamins, etc.)

____

____

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Date ______________ Patient Name ____ Date of Birth _____________

ALLERGIES:

Do you have any allergies to medications? ☐ Yes ☐ No If yes, please list medication(s) and reaction(s): ____________________

____

Do you have any of the following allergies?

☐ food ☐ latex ☐ environmental ☐ animal ☐ other: ____

SURGERIES / HOSPITALIZATIONS / INJURIES:

List all surgeries, hospitalizations (medical or psychiatric), and injuries, including the YEAR: ______________________________

____

____

FAMILY HISTORY

CHECK **any** of the following that apply (Other = other blood relatives)

ADD/ADHD	☐ Mother	☐ Father	☐ Siblings	☐ Other
alcoholism	☐ Mother	☐ Father	☐ Siblings	☐ Other
anxiety disorder	☐ Mother	☐ Father	☐ Siblings	☐ Other
bipolar disorder	☐ Mother	☐ Father	☐ Siblings	☐ Other
cancer	☐ Mother	☐ Father	☐ Siblings	☐ Other
depression	☐ Mother	☐ Father	☐ Siblings	☐ Other
dementia	☐ Mother	☐ Father	☐ Siblings	☐ Other
diabetes	☐ Mother	☐ Father	☐ Siblings	☐ Other
drug abuse	☐ Mother	☐ Father	☐ Siblings	☐ Other
genetic disorder	☐ Mother	☐ Father	☐ Siblings	☐ Other
heart disease	☐ Mother	☐ Father	☐ Siblings	☐ Other
high blood press.	☐ Mother	☐ Father	☐ Siblings	☐ Other
high cholesterol	☐ Mother	☐ Father	☐ Siblings	☐ Other
learning problems	☐ Mother	☐ Father	☐ Siblings	☐ Other
MS	☐ Mother	☐ Father	☐ Siblings	☐ Other
OCD	☐ Mother	☐ Father	☐ Siblings	☐ Other
panic disorder	☐ Mother	☐ Father	☐ Siblings	☐ Other
schizophrenia	☐ Mother	☐ Father	☐ Siblings	☐ Other
seizures/epilepsy	☐ Mother	☐ Father	☐ Siblings	☐ Other
stroke	☐ Mother	☐ Father	☐ Siblings	☐ Other
suicide	☐ Mother	☐ Father	☐ Siblings	☐ Other
thyroid problems	☐ Mother	☐ Father	☐ Siblings	☐ Other
tumors	☐ Mother	☐ Father	☐ Siblings	☐ Other

HEALTH RISK ASSESSMENT

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? ______________________

Do you smoke or use other forms of tobacco? ☐ Yes ☐ No If yes, how many times per day? ________________________

Have you ever used recreational/street drugs? ☐ Yes ☐ No If yes, date/amount/frequency?_________________________

Have you ever misused prescription drugs? ☐ Yes ☐ No If yes, date/amount/frequency?_________________________

Has drinking or drugs ever caused problems in any of the following areas:

☐ family ☐ employment ☐ legal ☐ emotional ☐ social ☐ financial ☐ behavioral ☐ physical

Does a relative, loved one, friend, court or employer think so? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No If yes, how often? ____________________________________

Are you pregnant? ☐ Yes ☐ No

What is your employment status? ☐ full time ☐ part time ☐ unemployed ☐ retired ☐ disabled

Are there any significant issues affecting family/significant other? ☐ Yes ☐ No If yes, please explain: __________________________

____

Describe your social support network (e.g. family, friends, etc): ____

Have you ever attempted suicide? ☐ Yes ☐ No If yes, when and by what means? _____________________________________

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Instructions for Medical and Health History Form

The "Medical History and Health History" form is a very important document for the initial patient visit. Keep in mind that most patients dislike filling out forms when they arrive and sometimes they do not bring all the necessary information with them. By completing this form ***before*** they arrive, not only do they save both the practice and themselves some time, the doctor also has the necessary information to meet documentation requirements for Review of Systems and Health History.

The information on this form helps the provider correctly assess the patient's condition and appropriately review concurrent conditions which may contribute to their reason for the encounter.

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