Medical History Form Date:_____

Name:_____DOB_____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

Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____

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_____

_____

Name:_____DOB_____Date_____

CARDIOVASCULAR

☐ ☐ High Blood Pressure
Controlled / Uncontrolled_____
☐ ☐ Chest Pain_____
☐ ☐ Heart Murmur_____
☐ ☐ Heart Attack _____
☐ ☐ 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 Cocaine Methamphetamine
Heroin Ketamine
Other Recreational drugs_____
Last Use_____
☐ ☐ History of assault_____
☐ ☐ History of violent behavior_____

_____

_____

☐ ☐ Other_____

_____

_____

_____

_____

_____

_____

PAST SURGICAL HISTORY ☐ None

_____

_____

_____

Name:_____DOB_____Date_____

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:**_____

_____

_____

Patient Signature_____Date_____Time_____