**MEDICAL HISTORY**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_ Approximate Weight: \_\_\_\_\_\_\_\_\_\_\_

Main reason for this psychiatric evaluation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications**: Please list medication name, dosage, duration of use, and name of prescriber; also include over the counter medications and supplements.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Medication Name* |  *Dosage* | *Duration(months/years)* | *Prescriber* |  |
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**Medication Allergies**: \_\_\_\_\_ None \_\_\_\_\_Yes Please list allergies and reactions below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address/Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current therapist/counselor**: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address/Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been previously treated by a Psychiatrist? \_\_\_\_\_Yes \_\_\_\_\_ No

Do you have a Mental Health Advanced Directive? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please provide copy.

Have you ever been **admitted** to the hospital **for Mental Health** reasons? (i.e. an inpatient psychiatric admission)

\_\_\_\_\_ Yes \_\_\_\_\_ No Please list hospital(s) with date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have or have you had in the past….**

Heart Problems? **□** No **□** YesDescribe: **□** Irregular Heart Rhythm/Arrhythmia **□** Coronary Artery Disease

 □ Angina □ Heart Attack

 □ Congestive Heart Failure

 □ Valve problem or murmur

 □ Pace Maker □ Defibrillator

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High blood pressure? □ No □ Yes Treatment w/ medication □ No □ Yes

High Cholesterol? □ No □ Yes Treatment w/ medication □ No □ Yes

Lung Problems? □ No □ Yes Describe: □ Asthma □ Emphysema/COPD

 □ Pneumonia □ Bronchitis

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Digestive Problems? □ No □ Yes Describe: □ Hiatal Hernia □ Reflux

 □ Gall Stones □ Ulcer

 □ Jaundice □ Hepatitis

 □ Bleeding Ulcers □ Liver Disease

 □ Bariatric Surgery □ Pancreatitis

 □ Hemorrhoids

 □ Crohn’s □ Ulcerative Colitis

 □ Diverticulosis/Diverticulitis

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Problems? □ No □ Yes Describe: □ Kidney Stones □ Dialysis

 □ Kidney Failure

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nervous System Problems? □ No □ Yes Describe: □ Headaches □ Migraines

 □ Head Injury □ Concussion

 □ Stroke □ Mini-Strokes/TIA

 □ Fainting □ Dizziness

 □ Falling □ Seizures

 Date of Last Seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

Endocrine Problems? □ No □ Yes Describe: □ Diabetes (Pill/Diet Controlled)

 □ Diabetes (Insulin Controlled)

 □ High Thyroid □ Low Thyroid

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Illnesses? □ No □ Yes Describe: □ Multiple Sclerosis

 □ Auto Immune Disease

 □ Immune System Compromise

 □ HIV/AIDS

 □ Fibromyalgia □ Chronic Fatigue

 □ Osteoporosis/Osteopenia

 □ Gout □ Arthritis

 □ Bleeding Problems

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have or have had in the past….**

Abnormal Laboratory Tests? □ No □ Yes Describe: □ Anemia □ Bleeding Problems

 □ Elevated Liver Function Tests

 □ Limited Kidney Function

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infectious Disease History? □ No □ Yes Describe: □ Shingles □ TB/Tuberculosis

 □ HIV/AIDS □ Lyme’s Disease

 □ MRSA

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer/Pre-cancer? □ No □ Yes Describe: Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Chemotherapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Radiation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Recurrence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Problems? □ No □ Yes Describe: □ Glaucoma □ Blindness

 □ Macular Degeneration

 □ Double Vision □ Blurred Vision

 □ Cataracts

 Last Eye Exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Pain? □ No □ Yes Describe: □ Back Pain □ Neck Pain

 □ Joint Pain (Hands/Feet)

 □ Joint Pain (Shoulders/Hips)

 Current Pain Level: Scale 1-10

 (1=Minimum/10=Worst): \_\_\_\_\_ Lowest Pain Level: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Highest Pain Level: \_\_\_\_\_\_\_\_\_\_\_\_\_

Genito-Urinary Problems? □ No □ Yes Describe: □ Bladder Incontinence/Wetting

 □ Bowel/Intestine Problems

 □ Prostate □ Difficulty Urinating

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women Only: Currently having menstrual cycles? □ No □ Yes Describe birth control method,
 if applicable:

 Post-Menopausal? □ No □ Yes □ Condoms/Diaphragm

 Currently pregnant? □ No □ Yes □ Oral Contraceptives

 Currently breast feeding? □ No □ Yes □ Vasectomy of Partner

 Planning pregnancy? □ No □ Yes □ Tubal Ligation

 Using birth control? □ No □ Yes □ IUD □ Implant

Please list any other medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all surgeries and approximate dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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