**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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