Aspire Wellness

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PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Reason for Referral (current problems):

_____

_____

_____

_____

MEDICATIONS: List all prescription and over the counter drugs, their strength (mg) and # of tablets/day you are currently taking.					
Drug	Strength (mg,mcg)	Number Taken Per Day	Drug	Strength (mg, mcg)	Number Taken Per Day

ALLERGIES: List all known allergies, including medications and reactions	
Allergy:	**Reaction:**

MEDICAL HISTORY: Indicate if you have ever had any of the following:

☐ Anemia ☐ Arthritis ☐ Asthma/COPD/emphazema ☐ Auto immune disorder
☐ Cancer ☐ Diabetes ☐ Heart Disease/High Blood Pressure ☐ Kidney Disease
☐ Learning Disorder ☐ Liver disease/Hepatitis ☐ Seizure Disorder ☐ Thyroid Disease

Please indicate if you have ever been diagnosed with any of the following:

☐ ADHD ☐ Anxiety ☐ Autism ☐ Bipolar disorder ☐ Depression
☐ Eating Disorder ☐ Personality Disorder ☐ Post-Traumatic Stress Disorder ☐ Psychosis ☐ Substance-Use Disorder

Please list all previous psychiatric medications:

_____

_____

_____

_____

Have you ever been psychiatrically hospitalized? ☐ Yes ☐ No Have you ever been treated with ECT, TMS or Spravato? ☐ Yes ☐ No

Please indicate which of the following substances you are currently using:

☐ Tobacco ☐ Alcohol ☐ Marijuana ☐ Other substances ☐ None

FAMILY HISTORY: Please indicate if an immediate family member has ever had one of the following conditions:

☐ Heart Disease ☐ Cancer ☐ Anxiety ☐ High Blood Pressure ☐ Kidney Problems
☐ Depression ☐ Stroke ☐ OCD ☐ Substance Use Disorder ☐ PTSD
☐ Schizophrenia ☐ Bipolar Disorder ☐ Diabetes ☐ Seizure Disorder ☐ Unknown
☐ Adopted