PATIENT MEDICAL HISTORY FORM **Date**_____

Your Name:_____ Date of Birth:_____

What is the reason for this visit?_____

ALLERGIES_____

ANY ADVERSE DRUG REACTIONS? Please list drug and type of reaction_____

_____

TELL US ABOUT YOURSELF: Primary Care Physician_____**phone**_____

Home situation (circle, or add in writing):

Single_____ Married (how long_____) Separation(how long____) Divorced (how long_____) Widowed (how long_____)

Domestic partnership(how long_____) Children?#_____ Ages_____ Other _____

Employment:

Status: full-time__◯__ part-time__◯__ retired__◯__ disabled__◯__ homemaker__◯__

Occupation/type of work/jobs:_____

Education: _____

Habits: Do you smoke? No_☐_ Yes_☐_ If yes, how long_____ how many packs per day?_____

If you have quit, how long ago?_____

Do you want to quit?_____

Do you use alcohol? No_☐_ Yes_☐_ If yes, how often do you drink?_____how much?_____

If you have quit, how long ago?_____

Do family or friends worry about your alcohol intake? _____

Have you ever had problems with drug use?_____

Are you currently using marijuana? how often_____how much_____ Soboxone/Methadone yes_☐__ no__☐__

Are there any religious or cultural circumstances that will impact your treatment?_____

Are there any personal strength or limitation that will affect your treatment?_____

Are you currently using any community recourses?_____

(Support group, social service, school base services or other social support.)

Are you interested in any education or information for community resources available to you? _____

MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS

Herbal preparation	Dose	How often taken

Patient's Name_____ Date of Birth_____

FAMILY HISTORY:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Received psychiatric treatment								
Other								

SYMPTOM REVIEW

Any check marks please list date of occurrence and treating physician

Gastrointestinal (onset date_____Treating Dr_____)

- ■ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ history of liver disease or abnormal liver tests

Cardiovascular (onset date_____Treating Dr_____)

- ■ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure

Pulmonary/lungs (onset date_____Treating Dr_____)

- ☐ shortness of breath
- ☐ persistent cough
- ☐ asthma or wheezing

Muscle/joint/bone(onset date_____Treating Dr_____)

- ☐ swelling of ankles or legs
- ☐ pain, weakness or numbness in
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic (onset date_____Treating Dr_____ _____)

- ☐ history of stroke
- ☐ blackouts or loss of consciousness

General (onset date_____Treating Dr_____)

- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat (onset date_____Treating Dr_____)

- ☐ blurred vision
- ☐ other change in vision
- ☐ loss of hearing
- ☐ sinus problems

Genitourinary (onset date_____Treating Dr_____)

- ☐ frequent or painful urination
- ☐ blood in urine

Skin (onset date_____Treating Dr_____)

- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine (onset date_____Treating Dr_____)

- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Therapy (onset date_____Clinician_____)

- ☐ currently active in therapy
- ☐ type of therapy: CBT, DBT other_____
- ☐ Filled out QBH release form for coordination of care
- ☐ Refused release form_

Anything else?

- ☐ Are you experiencing an unusually stressful situation?_____
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit?_____

Any behavioral history of bullying, domestic or sexual abuse, and/or traumatic situation?_____

Perpetrator of the trama, relative_____, self _____ or other_____