

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

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 trauma, relative _____, self _____ or other _____

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_