Medical History Form

PLEASE NOTE: Form must be completed in full in order to be seen by your provider.

Patient Name: _____ DOB:_____ Appointment Date: _____ Page 1
Sex at birth: ( ) Male ( ) Female Age: _____

>Marital Status: Single____ Married _____ ->How many times? ___ Last Marriage, How long? _____
Divorced: ____ How many times? _____ Last Divorce, How long ago? _____
Widowed: _____ how long? _____

HEIGHT: _____ WEIGHT: _____ Weight One year ago: _____ 5 years ago: _____

>Spouse's Name: _____ Age: _____

>Referred by: _____

>Primary Care Physician Name and Phone: _____

>Emergency Contact Name: _____ Phone: _____
Relationship to Patient: _____

>Pharmacy Name: _____ Pharmacy Phone: _____
Pharmacy Street or Intersection:_____

***>Medication ALLERGIES?** Specify drug name and reaction: _____
_____
_____

>Preferred Language: English Arabic Chinese French German Italian Japanese
Korean Russian Sign Languages Spanish Other _____

>Preferred Contact Method: Email Cell Phone Home Phone Work Phone Written(mail)

Federal Government Classifications for Race and Ethnicity:
>Race ☐White ☐Black or African American ☐Asian ☐Other ☐Refused to answer
☐American Indian or Alaskan Native ☐Native Hawaiian or Other Pacific Islander
>Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Refused to answer

**>>REASON FOR APPOINTMENT TODAY (list symptoms): _____
_____

CHILDREN AND ADOLESCENTS ONLY
(complete only for Children or Adolescents <18 yrs old)

Name and Address of Birth Hospital:_____

During pregnancy, did biological mother have any of the following complications?

___Amniocentesis
___Emotional Problems
___High Blood Pressure
___No prenatal care
___Vaginal bleeding
___Anemia
___Excessive weight gain
___High fever
___Placenta Previa
___Vaginal infection
___Diabetes Mellitus
___German Measles
___Kidney problems
___Premature labor
___Other infection

Unknown/Other, explain:

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CHILDREN AND ADOLESCENTS ONLY(continued)

During pregnancy, did biological mother use any of the following?

___Tobacco ___ Alcohol ___Street Drugs ___Unknown

Explain: _____

Any problems with labor and/or delivery? _____ None

___C-Section ___Jaundice ___Breathing ___Premature at ___ Months

Developmental Milestones(age for): Walk _____ Talk _____ Toilet Training _____

Developmental Abnormalities _____ Bedwetting _____ Soiling Underwear_____

Are immunizations up to date? ____YES ___NO

School History:Current Grade(1-12) in School _____ **Indicate (PV) private (PU) public**

(circle grades)

Name of Pre K_____

Name of Elementary: _____ AVG GRADES A B C D F

Name of Middle School: _____ AVG GRADES A B C D F

Name of High School:_____ AVG GRADES A B C D F

Has child been tested for an IEP (Individualized Education Plan)? ___YES ___NO

History of / or current placement in Special Eduction? ___ How many hours per day? _____

Due to:___ Learning problems ___ Behavior problems

Ever been expelled or suspended? ___YES ___NO REASON_____

Other education related problems? _____

Check any that apply:

_____ Agression toward people and/or Animals
_____ Argues with adults
_____ Blurts out answers before done
_____ Deceitfulness
_____ Destruction of Property
_____ Easily Distracted
_____ Expressive language problems
_____ Fails to follow through
_____ Fidgets
_____ Forgetful
_____ Hostile and defiant
_____ Hyperactivity
_____ Impulsive
_____ Inattention
_____ Interrupt or intrude
_____ Leaves seat
_____ Listening problems
_____ Loses temper

_____ Poor math
_____ Poor reading
_____ Poor written expression
_____ Organizing problems
_____ Problems with communication
_____ Receptive problems
_____ Refuses to comply
_____ Reluctant to do academics
_____ Runs around
_____ Social Personal skills
_____ Speech production
_____ Spiteful/Vindictive
_____ Talks excessively
_____ Threatening behavior
_____ Touchy
_____ Trouble with Leisure games, quietly "on the go"
_____ Violates all rules
_____ Won't wait turn

_____ Encopresis (passes feces in inappropriate places "Intentional, at least once a month for 3 months")
_____ Enuresis (repeated voiding urine in bed or clothes intentional or unintentional "at least 2/week for 3 months)

_____ Child is at least 5 years old and the behavior noted above is not due to physical problem or diuretic use.

When does "bed wetting" happen most? ___At Night ___During the Day ___Both

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PRESENTING PROBLEMS:

Check any that Apply:	PAST	NOW	How long ago did it BEGIN	FILL IN ONLY IF CURRENT PROBLEM: PLEASE INDICATEE MILD/MODERATE / SEVERE	What helps	What makes it worse
Addiction to Internet						
Agitation						
Anxiety, jumpy						
Concentration Problems						
Crying spells: How often?						
Delusions: _____						
Depressed mood						
Distrustful						
Easily Distracted						
Eating Disorder						
Excessive worrying/Cannot control						
Feelings of worthlessness						
Hallucinations:						
Homicidal thoughts						
Hypersomnia trouble staying awake during the day						
Impulsive						
Indecisive (daily) Can't make						
Irritable						
Insomnia (can't sleep): How						
Loss of interest in all activities						
Memory Problems						
Muscle tension or cramps						
Nervous or upset easily						
Phobias or Fears _____						
Problems with relationships:						
Problems with thinking						
Restless/ Irritability/ Agitation/						
Shortness of Breath						
Slurred Speech						
Stress (important stress in life)						
Stuttering						
Suspicious or distrustful of others						
Suicidal thoughts						
Tired or easily fatigued						
Trouble getting along in public						
Trouble with Work Functions						
Want to avoid people						

Accidents

Has the patient been in involved in any type of accident? ___NO ___YES

If yes, what type and when?

___Work related _____ Date ___ Auto _____ Date

___ Fall _____Date ___ Other _____Date, Explain: _____

If yes, are you currently receiving treatment? ___YES ___NO

If yes, Name of facility or doctor(s) providing treatment: _____

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Patient Name: _____ DOB:_____ Appointment Date: _____ Page 4

Have you been exposed to a trauma? If so, please give brief description ==>	_____ _____ _____					
Indicate which of these problems are associated with the trauma	PAST	NOW	How long ago did it BEGIN	PLEASE INDICATEE MILD/MODERATE / SEVERE	What helps	What makes it worse
Fear						
Helplessness Horror						
Uncontrollable intrusive distressing						
Recurring Dreams of the events						
Flashbacks						
Physical reaction on exposure to						
Avoidance related to trauma						
Efforts to avoid thoughts feelings or						
Unable to recall important aspect of						
Avoidance of activities, places,						
recollections of trauma						
Loss of interest or participation in						
activities						
Feeling detached or estranged from						
Pessimism						
Outbursts of anger						
Difficulty falling asleep						
Difficulty relaxing						
Easily startled						
Hypervigilent, overconcern about						
Significant distress in life						
Thoughts of hurting self						
Thoughts of hurting others						

Have you been or are you now in an abusive situation? NO _____ YES _____

If yes was it? Physical _____ Sexual_____ Emotional _____

Other _____

If Yes, please explain: _____

_____

MEDICAL HISTORY

PREVIOUS MEDICAL TREATMENT (including surgeries, broken bones, hospitalizations, injuries, etc.)

Location/Facility/Provider	Reason for Treatment	Approximate Date

Medical History Form

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Patient Name: _____ DOB:_____ Appointment Date: _____

Has the patient ever had any of the following? **(If so, please place a checkmark and indicate when)**

DESCRIPTION	Now ✓	Past Date?
SKIN		
Dryness/ itching/ rash		
Suspicious moles or lumps		
Hair and Nail changes		
HEENT		
Headaches		
Head injury		
Vision Problems		
Blurred/double Vision		
Flashing lights or specks		
Glaucoma or Cataract		
Decreased hearing		
Ringing in ears (tinnitus)		
Ear ache/ drainage		
Nose Bleeds		
Sore Throat		
Loss of voice/hoarseness		
Non-healing sores in mouth		
Bleeding gums		
Other:		
RESPIRATORY		
Chronic shortness of breath		
Painful breathing		
Chronic cough		
Coughing up blood		
Other:		
CARDIOVASCULAR		
Chest pain		
Palpitations		
Fainting spells		
Swollen ankles (edema)		
Other:		
GASTROINTESTINAL		
Trouble swallowing		
Persistent nausea/vomiting		
Diarrhea		
Constipation		
Heartburn/ Indigestion		
Change in appetite		
Change in appearance of stool		
Vomiting blood		
Rectal bleeding		
Regular use of laxatives		
Jaundice		
Gall Bladder problems		
Other:		

DESCRIPTION	Now ✓	Past Date?
URINARY		
Frequent or urgent urination		
Pain or burning on urination		
Incontinence		
Blood in urine		
Other:		
GENITAL		
Pain with sex		
Sexual Dysfunction		
Penile/vaginal discharge		
Method of contraception		
Woman: Date of last menses		
Other:		
MUSCULOSKELETAL		
Muscles or Joints Pain		
Muscle weakness		
Muscle stiffness or cramping		
Arthritis		
Chronic pain: Location		
Other:		
NEUROLOGIC		
Dizziness and/or Fainting		
Seizures/convulsions		
Numbness and/or tingling		
Tremor/hand shaking		
Other:		
ENDOCRINE		
Heat or Cold intolerance		
Excessive appetite		
Excessive thirst and urination		
Significant weight change		
Excessive sweating		
Other:		
HEMATOLOGIC		
Easy bruising or bleeding		
Swollen glands		
Other:		
INFECTIOUS DISEASE		
Hepatitis		
HIV OR AIDS		
STD: Specify		
Frequent infections		
Other:		

Anything else you want your provider to be aware of?

Pain Questionnaire:

Is patient in pain now? ___No ___ Yes -location?_____

If yes, please rate pain on scale of 1-10 (with 10 being most severe) and enter here _____

Is patient receiving care for pain? ___YES ___NO

If yes, please indicate treating Facility or Doctor: _____

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Patient Name: _____ DOB:_____ Appointment Date: _____

Please list ALL CURRENT medication.

Please include any over-the-counter (non-prescription) and herbal medications taken regularly.

Name of Medication	Dose (amount)	How often Taken	Started Date	Prescriber

PREVIOUS PSYCHIATRIC TREATMENT

List PAST any psychiatric medications that patient has previously been prescribed, by who and when:

Medication Name	When taken	Doctor's Name

Past Mental Health Treatment (Include outpatient treatment and hospitalizations below)

Location/Facility/Provider	Reason for Treatment	Approximate Date

Have you recently had suicidal thoughts? No___ Yes___ When?_____ IF YES: Plan____ Intent____
In the past have you ever had suicidal thoughts? No___ Yes___. If yes when?_____
Have you ever attempted suicide? No___ YES___ How many times?____ When? _____
How? (be specific)_____

Recent homicidal thoughts? No___ Yes___ Explain?_____ IF YES: Plan____ Intent____
In the past have you ever had homicidal thoughts? No___ Yes___. If yes when?____

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PERSONAL AND SOCIAL HISTORY

Patient was born in (city and state): _____

Who lives with you? _____

List Areas Where Patient has Lived:

City and State	Dates: From - to	Reason for moving

Has Patient ever lived or traveled abroad (outside of the U.S.)? (If so give details):

_____

Current Place of Employment: _____

Patient's current Occupation: _____

Does the patient enjoy their work_____

Has patient ever worked in the field of medicine, in any capacity (including volunteer)? No Yes (explain)

_____

List Past Occupations:

Occupation	Dates: From - to	Reason for Leaving the Job

How much and what type of physical exercise does the patient get? _____

_____

Hobbies or recreational activities: What and how often?_____

EDUCATION: (ADULTS ONLY >18 YEARS OLD)

Highest Grade Achieved: ☐ High School ☐ Some College ☐ College Degree ☐ Graduate Degree ☐ Other

Military Service: ☐ YES ☐ NO Discharge Date: _____
☐ Honorable ☐ Dishonorable ☐ Administrative ☐ Medical

ARRESTS/CONVICTIONS: ( ) NO ( ) YES **If Yes, give dates and reasons for arrests/convictions**

___ Gangs ___DUI/DWI ___Arrests ___Conviction

___ Detention ___Jail ___Probation ___Other

Explain_____

_____

Other current Legal Actions pending?

(**Accident**/Criminal/Civil/Divorce/Custody?):_____

Past Legal problems?_____

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Are you Disabled by Social Security? No ___ Yes___ How long? _____

Are you applying for disability benefits? No ____ Yes_____
If yes: Short term Disability _____ Long term Disability _____ Social Security Disability _____

***USE OF ALCOHOL** Social ☐ Excessive ☐ Dependent ☐ None ☐
Indicate how much and how often _____

***Tobacco Smoking?(check one)** ☐Never Smoker
☐Current Some Day Tobacco smoker ☐Current Every Day Tobacco smoker
☐Former Tobacco Smoker (When did you quit?) _____
***Other Smoking?** ☐Vape ☐Marijuana

***Current OR Past use of ILLEGAL DRUGS? ___No ___Yes If yes, explain**

TYPE	PAST	CURRENT	HOW OFTEN	SINCE/ HOW LONG

FAMILY HISTORY

Please give the following information about the health of patient's immediate family:

Relation	Sex (M/F)	Age if alive	Age at Death	Cause of Death	Relationship with patient? Good/Bad,	Medical and Psychiatric Health History
Mother	F					
Father	M					
Siblings	F M					
	F M					
	F M					
	F M					
	F M					
	F M					
	F M					
	F M					
Spouse	F M					
Children	F M					
	F M					
	F M					
	F M					
	F M					
	F M					

Who completed this form? _____ **Relationship to Patient** _____