

PATIENT HISTORY FORM

Date: ____/____/____		
NAME: _____		Birthdate: ____/____/____
Last	First	M. I.
Age: _____ Sex: <input type="checkbox"/> F <input type="checkbox"/> M		
How did you hear about this clinic?		
Describe briefly your present symptoms:		
Please list the names of other practitioners you have seen for this problem:		
Psychiatric Hospitalizations (include where, when, & for what reason):		
Have you ever had ECT? _____ Have you had psychotherapy? _____		

CURRENT MEDICATIONS		
Drug allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes To what?		
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

PAST MEDICAL HISTORY

Do you now or have you ever had:

- | | | |
|----------------------------------------------|----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify) _____
 Where were you born & raised? _____
 What is your highest education? High school Some college College graduate Advanced degree
 Marital status: Never married Married Divorced Separated Widowed Partnered/significant other
 What is your current or past occupation? _____
 Are you currently working? : Yes No Hours/week _____ If not, are you retired disabled sick leave?
 Do you receive disability or SSI? Yes No If yes, for what disability & how long? _____
 Have you ever had legal problems? (specify) _____
 Religion: _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

--

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL

- Recent weight gain; how much_____
- Recent weight loss: how much_____
- Fatigue
- Weakness
- Fever
- Night sweats

MUSCLE/JOINTS/BONES

- Numbness
- Joint pain
- Muscle weakness
- Joint swelling

Where?

EARS

- Ringing in ears
- Loss of hearing

EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

THROAT

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

HEART AND LUNGS

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

SKIN

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

BLOOD

- Anemia
- Clots

KIDNEY/URINE/BLADDER

- Frequent or painful urination
- Blood in urine

Women Only:

- Abnormal Pap smear
- Irregular periods
- Bleeding between periods
- PMS

PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulties with sexual arousal
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts
- Paranoia
- Mood swings
- Anxiety
- Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes <input type="checkbox"/> No <input type="checkbox"/>
CANNABIS: Marijuana, hashish, hash oil					Yes <input type="checkbox"/> No <input type="checkbox"/>
STIMULANTS: Cocaine, crack					Yes <input type="checkbox"/> No <input type="checkbox"/>
STIMULANTS: Methamphetamine—speed, ice, crank					Yes <input type="checkbox"/> No <input type="checkbox"/>
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes <input type="checkbox"/> No <input type="checkbox"/>
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes <input type="checkbox"/> No <input type="checkbox"/>
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes <input type="checkbox"/> No <input type="checkbox"/>
HEROIN					Yes <input type="checkbox"/> No <input type="checkbox"/>
STREET OR ILLICIT METHADONE					Yes <input type="checkbox"/> No <input type="checkbox"/>
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes <input type="checkbox"/> No <input type="checkbox"/>
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes <input type="checkbox"/> No <input type="checkbox"/>
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes <input type="checkbox"/> No <input type="checkbox"/>
OTHER: specify) _____ _____ _____					Yes <input type="checkbox"/> No <input type="checkbox"/>