PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ 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: ❑ No ❑ 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.		
13.		
14.		
15.		
16.		
17.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

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

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify)
Where were your 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 ☐ No ☐
CANNABIS: Marijuana, hashish, hash oil					Yes ☐ No ☐
STIMULANTS: Cocaine, crack					Yes ☐ No ☐
STIMULANTS: Methamphetamine—speed, ice, crank					Yes ☐ No ☐
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes ☐ No ☐
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes ☐ No ☐
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes ☐ No ☐
HEROIN					Yes ☐ No ☐
STREET OR ILLICIT METHADONE					Yes ☐ No ☐
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes ☐ No ☐
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes ☐ No ☐
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes ☐ No ☐
OTHER: specify)_____					Yes ☐ No ☐