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| **Patient History Form** |

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

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| **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. |  |
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| **Past medical history** |
| Do you now or have you ever had: |  |  |
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| ❑ Diabetes | ❑ Heart murmur | ❑ Crohn’s disease |
| ❑ High blood pressure | ❑ Pneumonia | ❑ Colitis |
| ❑ High cholesterol | ❑ Pulmonary embolism | ❑ Anemia |
| ❑ Hypothyroidism | ❑ Asthma | ❑ Jaundice |
| ❑ Goiter | ❑ Emphysema | ❑ Hepatitis |
| ❑ Cancer (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Stroke | ❑ Stomach or peptic ulcer |
| ❑ Leukemia | ❑ Epilepsy (seizures) | ❑ Rheumatic fever |
| ❑ Psoriasis | ❑ Cataracts | ❑ Tuberculosis |
| ❑ Angina | ❑ Kidney disease | ❑ HIV/AIDS |
| ❑ Heart problems | ❑ Kidney stones |  |
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| Other medical conditions (please list): |  |
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| **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: |  |

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| **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: |
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| **Systems Review** |
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| **In the past month, have you had any of the following problems?** |
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| **General** | **NERVOUS SYSTEM** | **PSYCHIATRIC**  |
| ❑ Recent weight gain; how much\_\_\_\_ | ❑ Headaches | ❑ Depression |
| ❑ Recent weight loss: how much\_\_\_\_ | ❑ Dizziness | ❑ Excessive worries |
| ❑ Fatigue | ❑ Fainting or loss of consciousness | ❑ Difficulty falling asleep |
| ❑ Weakness | ❑ Numbness or tingling  | ❑ Difficulty staying asleep |
| ❑ Fever | ❑ Memory loss | ❑ Difficulties with sexual arousal |
| ❑ Night sweats |  | ❑ Poor appetite |
|  |  | ❑ Food cravings |
| **Muscle/Joints/Bones** | **STOMACH AND INTESTINES** | ❑ Frequent crying |
| ❑ Numbness | ❑ Nausea | ❑ Sensitivity |
| ❑ Joint pain | ❑ Heartburn | ❑ Thoughts of suicide / attempts |
| ❑ Muscle weakness | ❑ Stomach pain | ❑ Stress |
| ❑ Joint swelling | ❑ Vomiting | ❑ Irritability |
| Where? | ❑ Yellow jaundice | ❑ Poor concentration |
|  | ❑ Increasing constipation | ❑ Racing thoughts |
| **EARS** | ❑ Persistent diarrhea | ❑ Hallucinations |
| ❑ Ringing in ears | ❑ Blood in stools | ❑ Rapid speech |
| ❑ Loss of hearing | ❑ Black stools | ❑ Guilty thoughts |
|  |  | ❑ Paranoia |
| **EYES** | **SKIN** | ❑ Mood swings |
| ❑ Pain | ❑ Redness | ❑ Anxiety |
| ❑ Redness | ❑ Rash | ❑ Risky behavior |
| ❑ Loss of vision | ❑ Nodules/bumps |  |
| ❑ Double or blurred vision | ❑ Hair loss |  |
| ❑ Dryness | ❑ Color changes of hands or feet | **OTHER PROBLEMS:** |
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| **THROAT** | **BLOOD** |  |
| ❑ Frequent sore throats | ❑ Anemia |  |
| ❑ Hoarseness | ❑ Clots |  |
| ❑ Difficulty in swallowing |  |  |
| ❑ Pain in jaw | **KIDNEY/URINE/BLADDER** |  |
|  | ❑ Frequent or painful urination |  |
| **HEART AND LUNGS** | ❑ Blood in urine |  |
| ❑ Chest pain |  |  |
| ❑ Palpitations | **Women Only:** |  |
| ❑ Shortness of breath | ❑ Abnormal Pap smear |  |
| ❑ Fainting | ❑ Irregular periods |  |
| ❑ Swollen legs or feet | ❑ Bleeding between periods |  |
| ❑ Cough | ❑ PMS |  |
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| **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  |

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| **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 currentlyuse 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 □ |