PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

Use the opposite side of the page as necessary to complete your answers. **Please print legibly**.

Name ____

Address ____

Phone (w) _____________________ (h) ____________________ (c) ____________________

Email ____

DOB _____________________ Age ___________SS# _______________________________

Emergency Contact ____

Relationship to patient __________________________ Phone ___________________________

Primary care physician __________________________ Phone __________________________

Date of last physical ______________ Have you ever had an EKG? ( ) N Date ________________

Current or past medical conditions (check all that apply)

( ) Asthma/respiratory
( ) Cardiovascular (heart attack, high cholesterol, angina)
( ) Hypertension
( ) Epilepsy or seizure disorder
( ) GI disease
( ) Head trauma
( ) HIV/AIDS
( ) Diabetes
( ) Liver problems
( ) Pancreatic problems
( ) Thyroid disease
( ) STDs
( ) Abnormal Pap smear
( ) Nutritional deficiency

Other (Please describe) ____

____

____

MD NOTES ____

____

____

Significant Family Medical History ____

____

____

MD NOTES ____

____

Have you ever had **surgery** or been **hospitalized**? (Please describe) ___________________________________

____

____

MD NOTES ____

____

Childhood Illnesses

Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

Have you ever been diagnosed with a **psychiatric** or **mental illness**? (Please describe)

____

Have you ever taken or been prescribed **antidepressants**? ( ) N For what reason _________________________

Medication(s) and dates of use _______________________________ Why stopped _________________________

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later) ______________

____

____

Please list all current **herbal medicines**, **vitamin supplements**, etc. and how often you take them

____

MD NOTES ____

____

____

Please list any **allergies** you have (penicillin, bees, peanuts)

____

MD NOTES ____

Tobacco History

Cigarettes: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How many per day on average? __________ For how many years? __________

Pipe: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How often per day on average? __________ For how many years? __________

Have you ever been **treated for substance misuse**? ( ) N (Please describe when, where and for how long)

____

How long have you been **using substances?** ____

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? ( ) N (Please list) ______________________

____

____

What was your longest period of abstinence? ____

____

MD NOTES ____