Medical Hx

NAME________________________

DOB____________________

A. FAMILY MEDICAL HISTORY

Please check any of the following diseases or disorders in your family and extended family:

DISEASE / DISORDER	✓			✓		DISEASE / DISORDER	✓	
AIDS / HIV Positive			*High Blood Pressure*			*Addiction*		
Alcoholism			*Hypoglycemia*			*Anorexia*		
Anemia			*Kidney Disease*			*Anxiety Disorder*		
Arthritis			*Liver Disease*			*Attention Deficit Disorder*		
Asthma			*Migraine Headaches*			*Bulimia*		
Bleeding Disorders			*Miscarriage*			*Bi-Polar Disorder*		
Bronchitis			*Mononucleosis*			*Depression*		
Diabetes			*Multiple Sclerosis*			*Learning Problems*		
Emphysema			*Neurological Disorder*			*Obsessions/Compulsions*		
Epilepsy			*Seizures*			*Thinking Problems*		
Gastro-intestinal Problems			*Stroke*			*Schizophrenia*		
Glaucoma			*Thyroid Problems*			*Suicide*		
Goiter			*Tumors*			*Other:*		
Gout			*Ulcers*			*Other:*		
Heart Disease			*Other:*			*Other:*		
High Cholesterol			*Other:*					

B. PERSONAL MEDICAL HISTORY

Please check all that apply to your personal medical history:

DISEASE / DISORDER	✓		DISEASE / DISORDER	✓		DISEASE/DISORDER	✓	
AIDS/ HIV Positive			*High Cholesterol*			*Addiction*		
Alcoholism			*High Blood Pressure*			*Anorexia*		
Anemia			*Hypoglycemia*			*Anxiety Disorder*		
Arthritis			*Kidney Disease*			*Attention Deficit*		
Asthma			*Liver Disease*			*Bulimia*		
Bleeding Disorders			*Migraine Headaches*			*Bi-Polar Disorder*		
Bronchitis			*Miscarriage*			*Compulsions*		
Diabetes			*Mononucleosis*			*Depression*		
Emphysema			*Multiple Sclerosis*			*Learning Problems*		
Epilepsy			*Neurological Disorder*			*Obsessions*		
Gastro-intestinal Prob.			*Seizures*			*Thinking Problems*		
Glaucoma			*Stroke*			*Schizophrenia*		
Goiter			*Thyroid Problems*			*Suicide*		
Gout			*Tumors*			*Other:*		
Heart Disease			*Ulcers*			*Other:*		
Hepatitis			*Other:*			*Other:*		

Please check any of the following that apply to you personally:

	✓			✓	
Marital Problems			*Chronic Illness*		
Parent-Child Problems			*Physical Health Problems*		
Work Stress			*Loss or Trauma*		
Substance Abuse			*Victim of Crime*		

PLEASE COMPLETE BACK OF FORM

C. MEDICATIONS

Please list all medications you are currently taking:

MEDICATION	*DOSE*	*PRESCRIBING PHYSICIAN*

D. ALLERGIES

Please list all known allergies:

NAME OF ALLERGY

E. HEALTH HABITS

Please check all that apply:

HEALTH HABITS	√		OCCUPATIONAL ENVIRONMENT	√
Caffeine: *coffee tea soda*			**Work Stress** *Please Specify:*	
Nicotine: *cigarettes chewing tobacco*			**Heavy Lifting**	
Alcohol: *none social use abuse dependence*			**Hazardous Substances**	
Drugs: *Please List:*			**Work Related Trauma(s)**	
			Comments regarding above:	
Other: *Please List:*				

F. DEVELOPMENTAL HISTORY *(Children / Adolescent Patient Information Only)*

Please provide the following information:

Mother's pregnancy: ☐ *Normal* ☐ *Abnormal* *Complications included:* ____________________

Delivery: ☐ *Vaginal* ☐ *C-Section* *Complications included:* ____________________

Infant Health and Development:

☐ *feeding problems* ☐ *cholic* ☐ *health prob* ☐ *attachment difficulty* ☐ *other:* ____________________

Toddler Development:

☐ *motor delays* ☐ *speech language delays* ☐ *cognitive delays* ☐ *social/emotional prob.* ☐ *other:* __________

Family Status: ☐ *divorce* ☐ *custody conflicts* ☐ *single parent* ☐ *adoption* ☐ *family illness* ☐ *recent loss*

Please check all that apply: √

CONCERNS		CONCERNS		CONCERNS		CONCERNS		CONCERNS	
Depressed Mood		Separation Anxiety		Aggressive		Destroys Property		Delinquency	
Poor Concentration		Fears		Impulsive		Hurts Others		Drugs or Alcohol	
Weight Loss		Trauma		Inattentive		Hurts Animals		Smoking	
Appetite Change		Sexual Abuse Hx.		Distractible		Fire Setting		Learning Prob	
Sleep Problems		Witness to Violence		Bed Wetting		Lying		School Failure	
Irritability		Defiant		Soiling		Stealing		Truancy	

Other concerns: ____

______________________________________ ______/______/______

Signature *Date*