

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	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	DISEASE / DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	DISEASE / DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	DISEASE/DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
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	<input checked="" type="checkbox"/>	Chronic Illness	<input checked="" type="checkbox"/>
Parent-Child Problems	<input type="checkbox"/>	Physical Health Problems	<input type="checkbox"/>
Work Stress	<input type="checkbox"/>	Loss or Trauma	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	Victim of Crime	<input type="checkbox"/>

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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	OCCUPATIONAL ENVIRONMENT	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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)		
Other: Please List:			Comments regarding above:		

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	<input type="checkbox"/>	CONCERNS	<input type="checkbox"/>	CONCERNS	<input type="checkbox"/>	CONCERNS	<input type="checkbox"/>	CONCERNS	<input type="checkbox"/>
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 ____/____/____
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