Name/Practice Name: ______________________________
Address: ____
Address: ____
City, State, ZIP: _______________________________________
Phone: ____
Fax: ____

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) _______________________

DOB: ________________________ Age: _____________SS no.: __________________________________

Emergency contact: ____

Relationship to patient: _______________________________ Phone: ________________________________

Primary care physician: _______________________________ Phone: ________________________________

Date of last physical: ______________ Have you ever had an EKG? ( ) N ( ) Y 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) : ____

____

____

If there a family history of any of the illnesses listed above, **please put an "F" next to that illness**.

MD NOTES: ____

____

Is there a family history of anything NOT listed here? ( ) N ( ) Y (Please explain)

____

____

____

MD NOTES:

____

_

____

____

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

____

____

____

MD NOTES:

____

_

____

____

Childhood Illnesses

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

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? ( ) N ( ) Y

(Please describe)

____

Have you ever taken or been prescribed **antidepressants**? ( ) N ( ) Y 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 (eg, penicillin, bees, or 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 ( ) Y (Please describe when, where and for how long)

How long have you been **misusing 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 (   ) Y (Please list)

____

____

____

What was your longest period of abstinence? ____

____

Are you receiving, or have you ever received counseling support? (   ) N (   ) Y (Please describe when and for how long) ____

____

MD NOTES: