

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# _____

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)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma/respiratory | <input type="checkbox"/> Cardiovascular (heart attack, high cholesterol, angina) | |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Epilepsy or seizure disorder | <input type="checkbox"/> GI disease |
| <input type="checkbox"/> Head trauma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Pancreatic problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> STDs | <input type="checkbox"/> Abnormal Pap smear | <input type="checkbox"/> 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? (Please explain) _____

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 or a family member 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? _____
