HEALTH/MEDICAL INFORMATION

Patient Name _____ Clinic #_____

Person Filling out Form (if other than Patient): _____ Relationship: _____

General Health History (fill out in reference to patient)

Generally, how would you describe your (i.e. patient's) health? (Circle) poor fair good very good

Do you (i.e. patient) have any significant health problems currently? (☐ Yes ☐No). If Yes, please provide a brief explanation or information about these problems.

_____

_____

Have you (i.e. patient) had any significant health problems in the past? (☐ Yes ☐No). If Yes, please provide a brief explanation or information about these problems.

_____

_____

Briefly describe any past surgeries or hospitalizations for serious illness or injuries (What, where, when? etc.)

_____

_____

_____

Physician Information

Please list physician information for all family members participating in the Psychology Clinic:

	Physician Name	Address & Telephone #	Approximate Date of last visit
Self	_____	_____	
Spouse/ Partner	_____	_____	
Children/dependents:			
Name	_____	_____	
Name	_____	_____	
Name	_____	_____	

Medication and Substance Use

Are you (i.e. patient) taking any medications, to include over the counter or supplements? (☐ Yes ☐No). If Yes, please fill out attached medication log (page 2 of this form).

Do you (i.e. patient) use tobacco products? (☐ Yes ☐No). How many (average) cigarettes/day_____
Readiness to quit smoking LOW 1 2 3 4 5 6 7 8 9 10 HI

Do you (i.e. patient) use e-cigarettes or engage in vaping? (☐ Yes ☐No

Do you (i.e. patient) drink alcohol? (☐ Yes ☐No).
If yes, How many alcohol standard drinks (i.e.,12 oz beer, 4oz glass wine, drink 1.5.oz liquor) used per week?_____

Have you ever had a problem with alcohol and/or other drugs? (☐ Yes ☐No).
If yes, please explain: _____

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Medication Log (fill out in reference to patient)

A. Psychotropic Medications

Are you (i.e. patient) taking any Psychotropic medications (e.g., for anxiety, mood, ADHD, etc)? (☐ Yes ☐No). If yes, please list below.

Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____

B. General Medication

Are you (i.e. patient) taking any other Prescription medications (e.g., other medical issues)? (☐ Yes ☐No). If yes, please list below.

Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____

C. Over the Counter and Supplements

Are you (i.e. patient) taking any Over the Counter/Vitamins/Herbal medications? (☐ Yes ☐No). If yes, please list below.

Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____
Dosage (amount and times per day) _____
Medication _____ Reason _____

D. Other Information

If you (i.e. patient) are on medications, are you (they) experiencing any side effects?

_____

Have you (i.e. patient) missed any doses in the last week?

_____

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Health History Checklist (fill out in reference to patient)

Have you ever had or do you now have a problem with any of the following? If a couple fills this out, please initial for whom the condition applies. (Check all that apply):

Gastrointestinal/Hepatic/Endocrine

_____ Nausea
_____ Gastritis
_____ Ulcers
_____ Coughing Up Blood
_____ Pancreatitis
_____ Gallbladder/Stones
_____ Jaundice (yellow skin, eyes)
_____ Kidney Problem
_____ Hepatitis
_____ Diarrhea
_____ Colitis
_____ Rectal Bleeding
_____ Liver Problem
_____ Weight Loss/Gain
_____ Change in Appetite
_____ Anemia
_____ Thyroid Problems
_____ Always Thirsty
_____ Swollen Glands
_____ Low Blood Sugar

Muscular-Skeletal

_____ Developmental Disability
_____ Fractures/Broken Bones
_____ Chronic Pain
_____ Herniated Disk
_____ Muscle Weakness
_____ Joint Pain
_____ Arthritis
_____ Gout
_____ Fibromyalgia

Cardiovascular

_____ Chest Pains/Pressure
_____ Angina
_____ Fainting
_____ Lightheadedness
_____ Irregular Heart Beat
_____ High/Low Blood Pressure
_____ Rheumatic Fever
_____ Heart Valve Problems
_____ High Cholesterol

Pulmonary

_____ Allergies
_____ Shortness of Breath
_____ Chronic Cough
_____ Wheezing/Asthma
_____ Tuberculosis
_____ Pneumonia
_____ Chronic Respiratory Difficulties

Neurological

_____ Neurologic Condition
_____ Headaches
_____ Migraines
_____ Skull Fracture
_____ Epilepsy
_____ Stroke
_____ Paralysis
_____ History of Head Injury
_____ Blurred or Double Vision
_____ Memory Loss
_____ Unsteady Gait
_____ Loss of consciousness

Urinary/Genital

_____ Frequent Urination
_____ Burning on Urination
_____ Weak Urinary System
_____ Incontinence
_____ Urinary Tract Infection
_____ Blood in Urine
_____ Kidney Infection
_____ Penis/Vaginal Discharge
_____ Menstrual Difficulties
_____ Sexual Difficulties
_____ STD

Skin/Sensory Systems

_____ Sores/Abscesses
_____ Skin Rash
_____ Eye Trouble
_____ Hearing Loss
_____ Ringing in Ears
_____ Perforated Septum
_____ Nose Bleeds
_____ Gum Bleeding
_____ Mouth Sores
_____ Difficulty Swallowing

General

_____ Pregnancy (Females)
_____ Intersex or Transgendered
_____ Chronic Fatigue
_____ Frequent/Terrifying Nightmares
_____ Insomnia or Sleep Problems
_____ Fever/Chills
_____ Diabetes
_____ Cancer
_____ Trauma
_____ Emotional Difficulties
_____ Abuse Victim
_____ Suicidal thoughts or Attempts
_____ Caffeine Usage
_____ Alcohol Usage
_____ Tobacco Usage
_____ Marijuana Use
_____ Other Drug Use
_____ Withdrawal Symptoms
_____ Drug Reactions
_____ Other_____

DO NOT WRITE BELOW THIS LINE

Clinician Review/Summary _____

_____

_____

_____