Patient Health Information Form

Patient's Name _____ **Date of Birth** _____

Allergies to food, medications, other _____

Current Family Physician: _____ **Date of last physical:** _____

Are there currently or have there previously been problems with any of the following?

	Yes	No		Yes	No
Skin problems			Eating		
Wounds not healing/easy bruising			Alcohol		
Glaucoma/vision			Street drugs		
Gum(s)/Teeth			High blood pressure		
Hearing			Heart disease/chest pain		
Headaches			Rheumatic fever		
Head injuries			Nausea/vomiting		
Black outs/fainting			Ulcers		
Numbness/tingling			Liver disease/jaundice		
Thyroid problems			Ulcers		
Blood sugar			Kidney/bladder problems		
Sickle cell			Pregnancy (Due date_____)		
HIV/AIDS			Sexual function		
Fatigue			Difficulty walking/standing		
Anemia/Low blood count			Pain		
Breathing/shortness of breath			Sleeping too much		
Fever			Sleeping too little		
Gallstones			Lead/chemical exposure		
Cancer			Seizures		
			Change in weight		

Please describe:_____

_____

Have any family members had any of the following?

	Yes	No	Who
Depression			_____
Bipolar disorder			_____
Suicide			_____
Schizophrenia			_____
Eating disorder			_____
Anxiety disorder			_____
Alcohol/drug problems			_____
ADHD			_____
Thyroid problems			_____
Asthma			_____
Diabetes			_____
Stroke			_____
Dementia/senility			_____
Stomach problems			_____
Seizures (what kind)			_____
Heart problems			_____
Cancer (what Kind)			_____
High blood pressure			_____
Abnormal heart rhythm			_____
Sudden cardiac death			_____
Tics			_____

Have there been hospitalizations for any medical reasons such as illness, accidents, operations or tests?

Reason for Hospitalization	Date	How long?

Current Medications (including any over-the-counter or herbal preparations):

Name of Medication	Dosage	For What Reason	How Long	Side effects (if any)

Other Psychiatric Medications which have been taken in the past:

Name of Medication	Dosage	For What Reason	How Long	Side effects (if any)

Psychiatric care in the past (such as psychologist, psychiatrist, social worker, nurse, counselor or psychological testing)

For What Reason	When	By Whom	Type of Treatment	Were you hospitalized?

Currently using caffeine? ❒ Yes ❒ No **If yes, how much, how often?**_____

Currently using cigarettes? ❒ Yes ❒ No **If yes, how much, how often?**_____

Currently using alcohol? ❒ Yes ❒ No **If yes, how much, how often?**_____

Signature **Date**