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
( ) Hypertension
( ) Head trauma
( ) Liver problems
( ) STDs
( ) Cardiovascular (heart attack, high cholesterol, angina)
( ) Epilepsy or seizure disorder
( ) HIV/AIDS
( ) Pancreatic problems
( ) Abnormal Pap smear
( ) GI disease
( ) Diabetes
( ) Thyroid disease
( ) 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) __________________________

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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): _______________

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Please list all current **herbal medicines**, **vitamin supplements**, etc, and how often you take them: _____________

____

MD NOTES: ____

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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							
Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
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) ____

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MD NOTES: ____

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