MEDICAL HISTORY QUESTIONNAIRE

Date: _____

Patient Name: _____

Date of Birth: _____ Age:_____ Sex_____ Height_____ Weight_____

Occupation: _____

Please answer the following questions. Your answers are confidential.

1. *What symptoms made you seek treatment?*

   _____

   _____

2. *Have there been any changes in your general health within the last year? Yes _____ No _____*

   If yes, please specify: _____

   _____

3. *Are you now under the care of a physician? Yes_____ No_____*

   If yes, what is the condition being treated? _____

   _____

4. *What is the name of your primary care physician?*

   _____

   _____

   (Address, phone number)

5. *Have you experienced any serious illnesses, operations, medical or psychiatric hospitalizations?*

   If yes, please describe. Yes_____ No_____

   _____

   _____

6. *Are you currently taking any non-prescription medications (e.g., "over the counter" medications such as cold remedies, diet or sleeping aids, St. John's Wort). Yes_____ No_____*

   If yes, list name and dosage. _____

   _____

MODIFY

7. *Are you currently using any "recreational drugs?"* *Yes_____ No _____*
   If yes, which one(s), how often and how much? _____
   _____

8. *Do you drink any alcoholic beverages?* *Yes_____ No_____*
   If yes please specify amount. _____

9. *Do you drink caffeinated drinks?* *Yes _____ No _____*
   If yes, please specify amount per day. _____

10. *Do you have any allergies (including drug allergies or reactions)?* *Yes_____ No_____*
    If yes, please specify. _____

11. *Do you smoke cigarettes?* *Yes _____ If yes, packs per day/how long? _____ No_____*

If male, skip to question 14.

12. *Are you pregnant?* *Yes_____ No_____*

13. *Is your menstrual period late?* *Yes_____ No _____*

14. *Do you have or had any of the following diseases or problems. If you answer yes , please specify with dates and detail in the space indicated below.*

Seizures/epilepsy	*Yes_____ No_____*	*Head injury*	*Yes_____ No_____*
Anemia	*Yes_____ No_____*	*HIV*	*Yes_____ No_____*
Headaches	*Yes_____ No_____*	*Sleep problems*	*Yes_____ No_____*
Eating Problems	*Yes_____ No_____*	*Heart Problems*	*Yes_____ No_____*
Hyperthyroidism	*Yes_____ No_____*	*Hypertension*	*Yes_____ No_____*
Stroke	*Yes_____ No_____*	*Lung problems*	*Yes_____ No_____*
Sugar/Diabetes	*Yes_____ No_____*	*Hepatitis*	*Yes_____ No_____*
Cancer	*Yes_____ No_____*	*Venereal Disease*	*Yes_____ No_____*
Vision/eye problems	*Yes_____ No_____*	*Kidney Disease*	*Yes_____ No_____*
Dental problems	*Yes_____ No_____*	*Hearing problems*	*Yes_____ No_____*
Late Menstruation	*Yes_____ No_____*	*Other_____*	

_____
_____
_____

FAMILY MENTAL HEALTH HISTORY:

In this section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

1. Alcohol / Substance abuse	____*Yes*	____*No*	_____
2. Anxiety	____*Yes*	____*No*	_____
3. Depression	____*Yes*	____*No*	_____
4. Bipolar Depression	____*Yes*	____*No*	_____
5. Domestic Violence	____*Yes*	____*No*	_____
6. Eating Disorders	____*Yes*	____*No*	_____
7. Obsessive Compulsive Behavior	____*Yes*	____*No*	_____
8. Schizophrenia	____*Yes*	____*No*	_____
9. Suicide Attempts	____*Yes*	____*No*	_____
10. ADHD	____*Yes*	____*No*	_____