MODIFY

## Medical History:

*Date:* _____

*Patient Name:* _____ *Date of Birth:*_____

*Please answer the following questions. *Your answers are confidential**

*1. Please briefly explain the reason for your visit and any symptoms you are experiencing:*

_____

_____

_____

*2. Primary Physician:*_____ *Phone:*_____

*In the past year have you had a physical exam? Yes _____ No _____ Date of last exam:_____/_____/_____*

*3. Have there been any changes in your general health within the last year? Yes _____ No _____*
*If Yes, Please specify*_____

_____

*4. Are you currently under the care of a psychiatrist or other mental health professional? Yes_____ No_____*
*If Yes, Please specify what is the condition being treated?* _____

_____

**Name of your psychiatrist/mental health professional?* _____
**Would you like us to coordinate care with them? Yes_____ No_____ Phone:*_____

*5. Have you experienced any serious illnesses, operations, medical or psychiatric hospitalizations?*
*Yes_____ No_____ If yes, please describe.* _____

_____

_____

*6. Are you currently taking any non-prescription or prescription medications? Yes_____ No_____*
*If yes, list name and dosage along with your height* _____ *and weight*_____.

_____

_____

*7. Are there any spiritual /cultural factors you would like us to be aware of during your care?*
*Yes_____ No_____ If yes, please specify* _____

*8. Please check the following as pertains to you, if yes please specify details.*

**Allergies Yes_____ No_____ Specify:(include drug allergies/reactions)*_____
**Exercise Yes_____ No_____ How many times per week?* _____
**Meditation Yes_____ No_____ How often?*_____ *Is it helpful?*_____
**Trouble sleeping Yes_____ No_____ Specify:*_____

MODIFY

*9. Please check the following as pertains to you, if yes please specify details.*

| | | |
|---|---|---|
| **Smoke cigarettes* | *Yes_____ No_____* | *How many packs per day/how long?_____* |
| **Recreational drugs* | *Yes_____ No_____* | *How often?_____ How much?_____* |
| **Caffeine intake* | *Yes_____ No_____* | *How much per day?_____* |
| **Alcohol consumption* | *Yes_____ No_____* | *How much per day?_____ per week?_____* |
| **Gambling* | *Yes_____ No_____* | *How often?_____* |
| **Legal history* | *Yes_____ No_____* | *Specify:_____* |

*10. Are you pregnant? Yes_____ No_____ Is your menstrual period late? Yes_____ No_____*

*11. 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_____* | |

## ***MENTAL HEALTH HISTORY:***

*In this section below please identify if you or a family member have a history of the following.*

| | | | *Relationship* |
|---|---|---|---|
| *1. Alcohol / Substance abuse* | *____Self* | *____Family* | *_____* |
| *2. Anxiety* | *____Self* | *____Family* | *_____* |
| *3. Depression* | *____Self* | *____Family* | *_____* |
| *4. Bipolar Depression* | *____Self* | *____Family* | *_____* |
| *5. Domestic Violence* | *____Self* | *____Family* | *_____* |
| *6. Eating Disorders* | *____Self* | *____Family* | *_____* |
| *7. Obsessive Compulsive Behavior* | *____Self* | *____Family* | *_____* |
| *8. Schizophrenia* | *____Self* | *____Family* | *_____* |
| *9. Suicide Attempts* | *____Self* | *____Family* | *_____* |
| *10. ADHD* | *____Self* | *____Family* | *_____* |