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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# _____

Emergency Contact _____

Relationship to patient _____ Phone _____

Primary care physician _____ Phone _____

Date of last physical _____ Have you ever had an EKG? ( ) N Date _____

Current or past medical conditions (check all that apply)

( ) Asthma/respiratory ( ) Cardiovascular (heart attack, high cholesterol, angina)

( ) Hypertension ( ) Epilepsy or seizure disorder ( ) GI disease

( ) Head trauma ( ) HIV/AIDS ( ) Diabetes

( ) Liver problems ( ) Pancreatic problems ( ) Thyroid disease

( ) STDs ( ) Abnormal Pap smear ( ) 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 _____

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Is there a family history of anything NOT listed here? (Please explain) _____

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MD NOTES _____

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Have you ever had surgery or been hospitalized? (Please describe) _____

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MD NOTES _____

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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? (Please describe)

_____

Have you ever taken or been prescribed antidepressants? ( ) N 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) _____

_____

_____

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 (penicillin, bees, 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 (Please describe when, where and for how long)

_____

_____

How long have you been using 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							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? ( ) N (Please list) _____

_____

_____

What was your longest period of abstinence? _____

_____

MD NOTES _____

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