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MEDICAL HISTORY

All information is confidential

* Please complete all sides of this form so I can better care for you. Thank you. *

Patient Name: _____ Today's Date: _____

Birthplace: _____ Date of Birth: _____

What problems or concerns do you have now? _____

Please indicate how your illness or condition is *affecting* the following areas:

	<u>None</u>	<u>Little</u>	<u>Some</u>	<u>Much</u>	<u>Significant</u>	<u>N/A</u>
Marriage/relationship	1	2	3	4	5	n/a
Family	1	2	3	4	5	n/a
Job/school performance	1	2	3	4	5	n/a
Friendships	1	2	3	4	5	n/a
Hobbies	1	2	3	4	5	n/a
Finances	1	2	3	4	5	n/a
Physical abilities	1	2	3	4	5	n/a
Sexuality	1	2	3	4	5	n/a
Mood	1	2	3	4	5	n/a
Eating habits	1	2	3	4	5	n/a
Sleeping habits	1	2	3	4	5	n/a
Ability to concentrate	1	2	3	4	5	n/a
Ability to control anger	1	2	3	4	5	n/a
Spirituality	1	2	3	4	5	n/a

Please list all medical & health providers:

Primary care _____

Specialists _____

Other providers (Chiropractor, Acupuncture, etc.) _____

Do you have any allergies to:

Medicines _____

Other _____

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Current medicines (including birth control pills; eye/skin preparations; vitamins/herbs/supplements; and nonprescription preparations:

Name & dosage

Please list any surgeries you have had with dates: _____

Please list hospitalizations other than surgery: _____

Check mark if you or a family member have had:

You Family(who?)

You Family(who?)

___	_____	Asthma/breathing problems	___	_____	Lyme disease
___	_____	Heart problem	___	_____	Liver/kidney disease
___	_____	Stomach/intestinal problems	___	_____	Stroke
___	_____	Alcohol/drug problems	___	_____	Thyroid problem
___	_____	Diabetes	___	_____	Depression
___	_____	High blood pressure	___	_____	Anxiety
___	_____	Emotional/psychiatric issues	___	_____	Cancer
___	_____	HIV/AIDS	___	_____	Migraine

Alive (Y/N) Age Health Problems

Alive (Y/N) Age Health Problems

Mother	___	___	___	Sister(s)	___	___	___
Father	___	___	___	Brother(s)	___	___	___
Son(s)	___	___	___	Daughter(s)	___	___	___

GENERAL INFORMATION

Occupation (current or most recent) _____

Do you like your work? _____

Has anything at your workplace been bad for your health? _____

Who is in your household? Relationship? _____

Any pets? What kind? _____

Does anyone living with you have a chronic health problem? What? _____

Do you have:
Smoke alarms in home _____ Gun(s) in home _____
Have you had immunizations? _____
An Advance Directive (tells who makes decisions for you if you are unable to do so)? _____
Who is listed as your agent? _____
Marital/relationship status _____
Are you sexually active? _____ Partner: Male _____ Female _____

Habits Do you:

Smoke cigarettes? _____ #/day _____ For how long? _____ Have you quit? _____
When? _____
Drink alcoholic drinks: How many glasses/week of Beer _____ Wine _____ Liquor _____
Have a drinking problem? _____
Use street drugs? _____
Exercise? _____ How often? _____
What kind? _____
Have a good diet? _____
Eat fruits & vegetables (servings/day) _____
How many hours a day do you: Work _____ Sleep _____ Tv/computer/electronic games _____

PERSONAL INFORMATION

Do you often feel lonely or depressed? _____
Do you often cry? _____
Do you have trouble relaxing? _____
Do you worry a lot? _____
Do you have trouble sleeping? _____
Have you ever had psychotherapy or psychiatric help? _____
Have you ever used medicines for emotional or psychiatric help? _____

Have you ever been in the hospital for emotional or psychiatric problems? _____

Are you often anxious? _____
Are there problems within the family? _____
Are these: In the past? _____ Current? _____
Have you ever been emotionally or physically abused by your partner or someone important to you? _____

Within the last year have you been hit, slapped, kicked or otherwise physically hurt by someone? _____

Within the last year has anyone forced you to have sexual activities? _____

Are you afraid of your partner or anyone else? _____
