PATIENT MEDICAL HISTORY

PATIENT NAME:_____.

REASON FOR YOUR VISIT TODAY:_____.

MEDICAL ALLERGIES:_____.

PAST/CURRENT MEDICAL DIAGNOSES:

_____

OUTPATIENT PSYCHIATRIC TREATMENT/DIAGNOSIS HISTORY:

PSYCHIATRIC/MEDICAL HOSPITALIZATIONS & RELATED DIAGNOSIS:

_____

DO YOU SMOKE?		HOW MUCH?
DRINK ALCOHOL?		HOW MUCH?
DO YOU USE RECREATIONAL DRUGS?		HOW MUCH?
	NAME OF DRUGS:	

CHECK ALL THAT APPLY

	HIGH BLOOD PRESSURE		BLURRED VISION		WEIGHT LOSS/GAIN
	DIABETES		LOSS OF VISION		NAUSEA/VOMITING
	HIGH CHOLESTEROL		CHEST PAIN		HOT FLASHES
	STROKE		SHORTNESS OF BREATH		BACK PAIN
	ASTHMA		BLOOD IN SPUTUM		JOINT PAIN
	LOW/HIGH THYROID		CONSTIPATION		INSOMNIA
	CANCER		DIARRHEA		MOOD CHANGE
	HEADACHE		URINARY PROBLEMS		ANXIETY/NERVOUSNESS
	ACID REFLUX		BLOOD IN STOOL		DEPRESSION
	FATIGUE		SKIN RASH		MEMORY LOSS
	OTHER (PLEASE SPECIFY):				

FAMILY HISTORY

BIPOLAR DISEASE?		DEPRESSION?		SCHIZOPHRENIA?		ATTEMPTED SUICIDE?		SUBSTANCE ABUSE?	
YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
RELATION:		RELATION:		RELATION:		RELATION:		RELATION:	

Please list all medications, supplements, or herbs taken currently along with psychiatric medications/supplements/herbs taken in the past. If you need more room, please print and attach.

Dates: - Medication:_____Dose:_____Effective? Y N Side-effects?: Y N

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Dates: - Medication:_____Dose:_____Effective? Y N Side-effects?: Y N

Dates: - Medication:_____Dose:_____Effective? Y N Side-effects?: Y N

SIGNATURE OF PATIENT/GUARDIAN PRINTED NAME DATE

Dates: - Medication:__________________Dose:_________Effective? Y N Side-effects?: Y N

Dates: - Medication:__________________Dose:_________Effective? Y N Side-effects?: Y N

Dates: - Medication:__________________Dose:_________Effective? Y N Side-effects?: Y N

Dates: - Medication:__________________Dose:_________Effective? Y N Side-effects?: Y N

Dates: - Medication:________________ Dose:_________Effective? Y N Side-effects?: Y N

Dates: - Medication:_________________Dose:_________Effective? Y N Side-effects?: Y N

Dates: - Medication:_________________Dose:_________Effective? Y N Side-effects?: Y N

Dates: - Medication:_________________Dose:_________Effective? Y N Side-effects?: Y N

Dates: - Medication:_________________Dose:________ Effective? Y N Side-effects?: Y N

Dates: - Medication:_________________Dose:_________Effective? Y N Side-effects?: Y N

Dates: - Medication:_________________Dose:_________Effective? Y N Side-effects?: Y N

Dates: - Medication:_________________Dose:_________Effective? Y N Side-effects?: Y N

Dates: - Medication:_________________Dose:________Effective? Y N Side-effects?: Y N

Dates: - Medication:_________________Dose:________Effective? Y N Side-effects?: Y N

Dates: - Medication:_________________Dose:________Effective? Y N Side-effects?: Y N

Dates: - Medication:_________________Dose:________Effective? Y N Side-effects?: Y N