Patient Intake-Medical History

(To be completed by patient)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (cell) _____ (home) _____ (work) _____

D.O.B.: _____ Age: _____ SSN: _____

Email: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

Past Medical History

Current Medications

What medications are you currently taking? (please list)

Medication	Strength or Dosage	How often you take this medication?	Why do you take this medication?	Who prescribed this medication?

Allergies

Do you have any allergies? (please list)_____

_____

_____

Past Surgical History

Please List

Date	Type of Operation	Complications (describe)

Have you had any of the following problems?

Heart:	☐ Stroke	☐ Heart Attack	☐ High Blood Pressure
	☐ Blocked Arteries (head, neck, arm, etc.)		☐ Angina
Lungs:	☐ Emphysema	☐ TB	☐ Asthma/Respiratory
	☐ Pneumonia	☐ Obstructive Sleep Apnea	
Nerves:	☐ Anxiety	☐ Depression	☐ Numbness
	☐ Weakness	☐ Dizziness	☐ Epilepsy/Seizure Disorder
Stomach/Bowels:	☐ Bleeding Ulcers	☐ Hiatal Hernia/Reflux	☐ Constipation
	☐ GI Disease	☐ Meds Cause Trouble	
Kidneys/Liver:	☐ Kidney Failure	☐ Cirrhosis	☐ Yellow Jaundice
Glands:	☐ Low or High Thyroid	☐ Diabetes Mellitus	☐ Cancer
Joints:	☐ Rheumatoid Arthritis	☐ Muscle Disease	☐ Osteoarthritis
Blood:	☐ Low or High Blood Counts	☐ Clotting	☐ Easy or Free Bleeding
Misc.:	☐ Head Trauma	☐ STDs	☐ HIV/AIDS
	☐ Pancreatic Problems	☐ Abnormal Pap Smear	

Other:_____

_____

_____

Tobacco and Substance History

Cigarettes: Now? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

How many per day on average? _____ For how many years? _____

Pipe: Now? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

How often per day? _____ For how many years? _____

When did you quit? _____

Have you ever been treated for substance misuse? ☐ Yes ☐ No

If yes, please describe when, where, and for how long: _____

_____

_____

_____

_____

Substance Use History

	No	Yes (past or present?)	Route	How Much	Date/Time of Last Use	Quantity Last Used
Alcohol						
Benzodiazepines (Xanax,Valium,etc)						
Caffeine (pills or beverages)						
Cocaine						
Crystal Meth-amphetamine						
Heroin						
Inhalants						
LSD or hallucinogens						
Marijuana						
Methadone						
Pain Killers						
PCP						
Stimulants (Pills)						
Ecstasy						
Other						

Did you ever stop using any of the above because of dependence? ☐ Yes ☐ No

Please list: _____

_____

_____

What was your longest period of abstinence? _____

Social/Family History

Current occupation or last job: _____

Present employment status:

☐ Full Time ☐ Part Time ☐ Student ☐ Unemployed

☐ Retired ☐ Leave of Absence ☐ Homemaker

What type of work do/did you do there? _____

How long have/did you work there? _____

If you are currently not working, when was your last day of work? _____

Marital Status (choose one):

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Years Married: _____ Times Married: _____ Times Divorced: _____

Children: ☐ Yes ☐ No Current Ages:

_____

Residing with you? ☐ Yes ☐ No If no, where? _____

Present living situation (If living with more than one individual, check primary head of household):

☐ Alone ☐ With spouse ☐ With children ☐ With parents

☐ With friend ☐ With other family members

Do you have family nearby? ☐ Yes ☐ No If no, where? _____

Have you ever been arrested or convicted? ☐ Yes ☐ No

☐ DWI ☐ Drug-related ☐ Domestic Violence ☐ Other

Have you ever been abused? ☐ Yes ☐ No

☐ Physically ☐ Sexually ☐ Verbally ☐ Emotionally

Have you ever attended:

AA: ☐ Current ☐ Past

NA: ☐ Current ☐ Past

If you are not currently attending meetings, what factors led you to stop? _____

_____

Have you ever been in counseling or therapy? ☐ Yes ☐ No

Please describe: _____

Family History

Indicate which relative has had the following diseases (parents and siblings are most important)

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No significant history known										
Alcoholism/Drug abuse										
Alzheimer's										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Ovarian										
Cancer Prostate										
Cancer-Other (specify)										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression/Suicide/Anxiety										
Diabetes-Childhood Onset										
Diabetes-Adult Onset										
Emphysema (COPD)										
Genetic Disorder (specify)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease-other (specify)										
Hepatitis B or C										
High Blood Pressure-Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism/Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (specify)										