Behavioral Health and Education Specialists

Medical History Questionnaire

Patient's Name:		**Today's Date:**		
Parent/Guardian's Name (if under 18 years old):		**Patient Date Of Birth:**		
Marital Status:	❑ S ❑ M ❑ D ❑ W	**Height:**	**Weight:**	
Primary Care Physician's Name:		**Primary Care Physician Phone:**		
Date of Last Medical Exam:		**Primary Care Physician Fax:**		

Medical History

1) Do you have any allergies to medications? ❑ Yes ❑ No

2) List all medications you are currently taking (including all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin and diet supplements). Also, list any medications you take on an as-needed basis (such as Viagra, Albuterol, Nitroglycerin, etc):

❑ None ❑ See Below

Medication	Dose	How Often Do You Take The Medication	Name Of Prescriber	Date First Prescribed

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3) List all major injuries, surgeries and/or hospitalizations you have had in your life:

❑ None ❑ See Below

_____

_____

_____

_____

4) Are you pregnant and/or nursing? ❑ Yes ❑ No ❑ N/A

5) Do you wear glasses or contact lenses? ❑ Yes ❑ No

6) List any eye illnesses, diseases or problems you have experienced: ❑ None ❑ See Below

_____

_____

_____

Family Medical History

Do any blood relatives have any of the following medical conditions in their history (parents, grandparents, siblings, children, aunts, uncles, nieces, nephews, cousins; living or deceased) for the following conditions?

Disease/Condition	Yes	No	Unsure	Relationship To You
Arthritis				
Autoimmune Disease				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Lupus				
Thyroid Disease				
Other				

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Social History

1) Do you drive? ❑ Yes ❑ No ❑ N/A

2) Do you use tobacco products? ❑ No ❑ See Below

Type of Tobacco (e.g., chew, cigarettes, snuff, …)	How Often	How Much	Age Started	Age Stopped

3) Do you drink alcohol products? ❑ No ❑ See Below

Type of Alcohol (e.g., beer, wine, hard liquor…)	How Often	How Much	Age Started	Age Stopped

4) Do you use illegal drugs? ❑ No ❑ See Below

Type of Drug (e.g., cocaine, crack, heroin, marijuana, LSD, mushrooms, ecstasy…)	How Often	How Much	Age Started	Age Stopped

5) Have you ever been exposed to or infected with: ❑ Chlamydia ❑ Crabs ❑ Gonorrhea ❑ Hepatitis ❑ Herpes ❑ HIV/AIDS ❑ HPV ❑ Syphilis

❑ Other(s):_____

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Review Of Systems (Please mark a selection for each below)

System	No	Yes	Unsure		System	No	Yes	Unsure
Allergic/Immunologic					**Gastrointestinal**			
Allergies					Acid Reflux			
Immune System					Constipation			
Bones, Joints, Muscles					Diarrhea			
Arthritis/Joint Pain					**Genitourinary**			
Muscle Pain					Bladder			
Rheumatoid Arthritis					Incontinence			
Cardiovascular, Vascular					Kidney			
Aneurysm					Urinary Tract Infections			
Blood Clots					Uterus			
Cholesterol					**Integumentary**			
Diabetes					Skin			
Heart Attack					**Hematologic, Lymphatic**			
High Blood Pressure					Anemia			
Stroke					Bleeding Problems			
Vascular Disease					**Neurological**			
Constitutional					Coordination/Dizziness			
Fever					Headaches			
Weight Gain/Loss					Migraines			
Ear, Mouth, Nose, Throat					Seizures			
Chronic Cough					**Nutritional**			
Dry Throat or Mouth					Vitamin B12 Deficiency			
Hay Fever, Seasonal Allergy					Vitamin D Deficiency			
Nasal Congestion					**Respiratory**			
Post-Nasal Drip					Asthma			
Runny Nose					Chronic Bronchitis			
Endocrine					Emphysema			
Thyroid Glands								
Eyes								
Blurred/Double Vision								
Dryness/Itching								
Loss of Vision								

If you answered Yes to any of the above or have a condition(s) not listed, please list and note any medications you took to treat the condition(s):

_____

_____

_____ _____

Psychiatrist's Signature **Date**