

Name:

DOB:

Date:



**PAST MEDICAL HISTORY**

Do you now or have you ever had:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> Crohn's disease         |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Colitis                 |
| <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Pulmonary embolism  | <input type="checkbox"/> Anemia                  |
| <input type="checkbox"/> Hypothyroidism      | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Jaundice                |
| <input type="checkbox"/> Goiter              | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Hepatitis               |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia            | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever         |
| <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Kidney stones       |  |

Other medical conditions (please list):

**PERSONAL HISTORY**

Where were you born & raised?

What is your highest education?  High school  Some college  College graduate  Advanced degree

Marital status:  Never married  Married  Divorced  Separated  Widowed  Partnered/significant other

# of children: \_\_\_\_\_

Work Location:

**FAMILY HISTORY**

|          | IF LIVING |                      | IF DECEASED     |       |
|----------|-----------|----------------------|-----------------|-------|
|          | Age (s)   | Health & Psychiatric | Age(s) at death | Cause |
| Father   |           |                      |                 |       |
| Mother   |           |                      |                 |       |
| Siblings |           |                      |                 |       |
| Children |           |                      |                 |       |

**EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:**

Maternal Relatives:

Paternal Relatives:

Name:

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**SYSTEMS REVIEW**

**In the past month, have you had any of the following problems?**

**GENERAL**

- Recent weight gain; how much \_\_\_\_\_
- Recent weight loss: how much \_\_\_\_\_
- Fatigue
- Weakness
- Fever
- Night sweats

**MUSCLE/JOINTS/BONES**

- Numbness
- Joint pain
- Muscle weakness
- Joint swelling

Where?

**EARS**

- Ringing in ears
- Loss of hearing

**EYES**

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

**THROAT**

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

**HEART AND LUNGS**

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

**NERVOUS SYSTEM**

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

**STOMACH AND INTESTINES**

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

**SKIN**

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

**BLOOD**

- Anemia
- Clots

**KIDNEY/URINE/BLADDER**

- Frequent or painful urination
- Blood in urine

**Women Only:**

- Abnormal Pap smear
- Irregular periods
- Bleeding between periods
- PMS

**PSYCHIATRIC**

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulties with sexual arousal
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts
- Paranoia
- Mood swings
- Anxiety
- Risky behavior

**OTHER PROBLEMS:**

**WOMENS REPRODUCTIVE HISTORY:**

Age of first period:  
 # Pregnancies:  
 # Miscarriages:  
 # Abortions:  
 Have you reached menopause? Y / N    At what age?  
 Do you have regular periods?    Y / N

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