Ψ SOUTHEAST PSYCHIATRY

Medical History Form

Name:	DOB:

Have you or any immediate family member every been told you have:

	Self	Family
Cancer		
Diabetes		
High blood pressure		
Heart disease		
Angina/chest pain		
Stroke		
Osteoporosis		
Osteoarthritis		
Rheumatoid arthritis		

In the past 3 months have you or had you experienced:

A change in your health	
Nausea/Vomiting	
Fever/chills/sweats	
Unexplained weight change	
Numbness or tingling	
Changes in appetite	
Difficulty swallowing	
Changes in bowel/bladder function	
Shortness of breath	
Dizziness	
Upper respiratory infection	
Urinary tract infection	

Do you have a history of:

Allergies or Asthma (circle)	
Headaches	
Bronchitis	
Kidney disease	
Rheumatic fever	
Ulcers	
Sexually transmitted disease	
Seizures	

Are you currently:

Pregnant	
Depressed	
Under Stress	

Are your symptoms:

Getting worse	
The same	
Improving	

How is your sleep at night?

Fine	
Restless	
Only with medication	

Do you have problems with:

Hearing		Speech	
Vision		Communication	

Tobacco use:

Currently	
How many packs a day	
Years/months since quitting	

Alcohol use:

Currently	
How many drinks a day	
How many drinks in a week	
Years/months since quitting	

Date of last physical exam:_____

Name of current doctor:_____

List of current medications:_____

_____

_____

_____

_____

List any drug allergies:_____

_____

Patient Information: