Patient Name:_____

Patient History Form

Please complete the following:

Allergies: _____

Medical History: (please list any medical problems, ex. Hypertension, diabetes etc.) _____
_____
_____

Surgical History: (please list any previous surgeries with dates) _____
_____
_____

Mental Health Hospitalizations: (list year and reason) _____
_____

Family Psych History: (List any family mental health issues with relationship, ex. Depression, anxiety): _____
_____

Family History of Suicide: (List any family members who have committed suicide): _____

Social History:

Substance Abuse Yes No History Socially Occasionally
Alcohol Yes No History Socially Occasionally
If yes, please answer the following questions:
1. Have you ever felt you should cut down on your drinking? Yes No
2. Have people annoyed you by criticizing your drinking? Yes No
3. Have you ever felt bad or guilty about your drinking? Yes No
4. Have you ever hd a drink first thing in the morning to steady nerves or get over a hangover? Yes No
Tobacco: Yes: ____ packs per day Smokeless History: Quit ___ years ago Never used
Education: _____grade GED Trade/Voc High School Some college College Adv. Degree
Military History: Yes No # years:_____ Branch: _____
Where born and raised? _____ Raised by whom? _____
Financial Status: Student Retired Disabled Unemployed Employed: Full time Part time
Relationship History: Stable/supportive Abusive Poor No significant relationships
Number of Siblings: _____brothers _____sisters _____# living
Birth Order: Oldest Middle Youngest #_____
Living arrangements: House Apartment Nursing facility Assisted living facility
Alone With spouse With children Other:_____
Religious Affiliation: None Baptist Catholic Christian Church of Christ
Lutheran Methodist Other:_____
History of Abuse: Yes No Type: Physical Emotional Verbal Sexual
History of suicidal thoughts: Yes No Explain: _____
History of homicidal thoughts: Yes No Explain: _____
Any cultural beliefs/factors
that might affect treatment? _____
Number of children: _____ sons _____daughters _____# living
Social interests/activities: _____
Exercise: Yes No Type: _____ How often? _____
Legal problems? Yes No Explain: _____
Marital Status: Married (# times:_____) Divorced Separated Widowed Single, never married
Occupation (current or past): _____
Pets: Yes No Type: _____
Sexual activity: Yes No Monogamous relationship Birth control Condom Use
Other: _____

NAME: _____ Pharmacy: _____ Phone:_____

Current Medications: This form must be filled out completely and returned with your paperwork. Failure to bring the completed list WILL result in your appointment being rescheduled. If you do not know all the information requested or you are unable to complete the form, please contact your pharmacy as they can print a list of your medications for you. This is acceptable in place of this form.

MEDICATION NAME (Include "extended release" if used)	**DOSAGE** (mg of each pill)	**DIRECTIONS** (# of pills and times of day/frequency)	**MEDICAL CONDITION** (why med is taken)

VITAMINS, SUPPLEMENTS, HERBS (list all above)

FEMALE PATIENTS -- BIRTH CONTROL:

Oral contraceptive (list above)
Mirena IUD (list above)
Depo Provera (list above)
Hysterectomy: Total Partial (ovaries not removed)

Postmenopausal
Partner Vasectomy
None
Other: _____