# Patient History Form

**Patient Name**: _____

***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 had a drink first thing in the morning to steady nerves or get over a hangover? ☐ Yes ☐ No

Tobacco: ☐ Yes: _____ packs per day ☐ History: Quit _____ years ago
☐ Smokeless ☐ 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: _____

Legal problem? ☐ Yes ☐ No Explain: _____

Marital Status: ☐ Married (# times _____) ☐ Divorced ☐ Separated
☐ Widowed ☐ 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) |
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*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 _____