MEDICAL HISTORY

History of Present Illness Date:

Last Name: ______________________________MI: ___ First Name: __________________________ DOB: _____________

Please briefly describe what your main problem(s) are:
____

____

When did the symptoms start, their location, frequency, and associations.____

____

Did something happen (for example, a car accident, bad infection, or a severe stressful event) just before the symptoms began? ☐ Y / ☐ N
____

Past Medical History

ALLERGIES:
____

MEDICATIONS:
____

HOSPITALIZATIONS:
____

ROS: Weight ____________ Weight Loss/Gain? _____________________ Height _____________ Right Handed ☐ ☐ Left Handed ☐

Other problems you may have (e.g. psychological, asthma, high blood pressure, high cholesterol, diabetes, heart disease)?

____

SIG-EM-CAPS
CHECK THOSE STATEMENTS THAT APPLY TO YOU.

- ☐ Sleep: increase or decrease in sleep?
- ☐ Interest: loss of interest in activities?
- ☐ Guilt: depressed, lack of self worth?
- ☐ Energy: lack of energy or fatigue?
- ☐ Mood: depressed mood?
- ☐ Concentration: reduced or difficulty concentrating?
- ☐ Appetite: weight loss or gain?
- ☐ Psychomotor: anxiety or lethargy?
- ☐ Suicide: preoccupation with death or dying?
- ← Total Checked Answers

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FAMILY HISTORY: Family member's illness? ☐ Y / ☐ N, explain: ____

____

OTHER:

Are you married, single, separated, divorced, or widowed? *(circle one)*

Are you sexually active: ☐ Y / ☐ N Multiple Partners: ☐ Y / ☐ N

Females only:
Are you menopausal? When periods stopped? __________________ years ago.

Irregular periods *(describe)* ____

When was your last period? ____

SOCIAL HISTORY: Race____________________ Years Education ______ Where were you born ______________________

Are you married, single, separated, divorced, or widowed? *(circle one)*

What is your current living situation? ____

How many children do you have and their ages? ____

Do you currently smoke cigarettes? Y / N If yes, how many packs per day and when did you start smoking? ______________

What are the stresses going on in your life? ____

Do you drink alcohol? Y / N If so, at what age did you begin drinking? ____; how many drinks *(on average)* per day ______

CHECK THOSE STATEMENTS THAT APPLY TO YOU.

☐ Cut Down: do you ever feel you should cut down on alcohol or drugs?

☐ Annoyed: do you ever get annoyed at people criticizing your alcohol or drug use?

☐ Guilt: do you ever feel guilty for your alcohol or drug use?

☐ Eye Opener: do you ever use alcohol or drugs to get you going?

← Total Checked Answers

Any other symptom(s) or problem(s) (*please don't be bashful, list them all)*? ______________________________

____

Patient Signature ____ **Date** ____________________

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