

MEDICAL HISTORY FORM

Name _____ Birth date _____ Date _____

Do you: Smoke? _____ Packs per day _____ # Years smoked _____

Drink Alcohol? _____ Drinks per day _____

List any allergies you have to drugs, food or other items: _____

Are you currently under medical care for any reasons? If yes, please explain: _____

Past Psychiatric/Mental Health Care:

Therapist's Name: _____ For How Long and When: _____

List All Operations:

Operation Performed	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure: _____	Kidney Disease: _____	Asthma: _____
Stroke: _____	Bleeding Tendencies: _____	Mental Illness: _____
Cancer: _____	Seizures: _____	Diabetes: _____
Emphysema/COPD: _____	Heart Disease: _____	
Other Serious Illness: _____		

Have you had any of the following illnesses: (Please Circle)

Measles	Diabetes	Rubella(German Measles)	Thyroid Disease
Chickenpox	Mumps	Hepatitis	Whooping Cough
Eczema	STD	Scarlet Fever	Mono
Seizures	Meningitis	Rheumatic Fever	Diphtheria
Poliomyelitis	Asthma	Heart Murmur	Glaucoma
Bronchitis	Cancer	High Blood Pressure	Angina Pectoris
Ulcer	Heart Attack	Kidney Stones	

Other serious illnesses: _____

Signature _____ Date _____