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:_______________________________

Current Medications you are taking, including OTC: _________________________________

____

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: ______**	
Cancer: ______	**Seizures: ______**	**Mental Illness: ______**
Emphysema/COPD: ______	**Heart Disease: ______**	**Diabetes:______**

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___________________________