

Ashland Integrative Care PC
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PATIENT HISTORY FORM

Date: _____ / _____ / _____
NAME: _____ Birthdate: _____ / _____ / _____ <div style="display: flex; justify-content: space-around; font-size: small; margin-top: -10px;">LastFirstM. I.</div>
Age: _____ Sex: <input type="checkbox"/> F <input type="checkbox"/> M
How did you hear about this clinic?
Describe briefly your present symptoms:
Please list the names of other practitioners you have seen for this problem:
Psychiatric Hospitalizations (include where, when, & for what reason):
Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS
Drug allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes To what? Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:
Name of drug Dose (include strength & number of pills per day): How long have you been taking this?
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.

PAST MEDICAL HISTORY

Do you now or have you ever had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify) _____
 Where were you born & raised? _____
 What is your highest education? High school Some college College graduate Advanced degree
 Marital status: Never married Married Divorced Separated Widowed Partnered/significant other
 What is your current or past occupation? _____
 Are you currently working? : Yes No Hours/week _____ If not, are you retired disabled sick leave?
 Do you receive disability or SSI? Yes No If yes, for what disability & how long? _____
 Have you ever had legal problems? (specify) _____
 Religion: _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL

- Recent weight gain; how much_____
- Recent weight loss: how much_____
- Fatigue
- Weakness
- Fever
- Night sweats

MUSCLE/JOINTS/BONES

- Numbness
- Joint pain
- Muscle weakness
- Joint swelling

Where?

EARS

- Ringing in ears
- Loss of hearing

EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

THROAT

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

HEART AND LUNGS

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

SKIN

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

BLOOD

- Anemia
- Clots

KIDNEY/URINE/BLADDER

- Frequent or painful urination
- Blood in urine

Women Only:

- Abnormal Pap smear
- Irregular periods
- Bleeding between periods
- PMS

PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulties with sexual arousal
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts
- Paranoia
- Mood swings
- Anxiety
- Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes <input type="checkbox"/> No <input type="checkbox"/>
CANNABIS: Marijuana, hashish, hash oil					Yes <input type="checkbox"/> No <input type="checkbox"/>
STIMULANTS: Cocaine, crack					Yes <input type="checkbox"/> No <input type="checkbox"/>
STIMULANTS: Methamphetamine—speed, ice, crank					Yes <input type="checkbox"/> No <input type="checkbox"/>
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes <input type="checkbox"/> No <input type="checkbox"/>
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes <input type="checkbox"/> No <input type="checkbox"/>
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes <input type="checkbox"/> No <input type="checkbox"/>
HEROIN					Yes <input type="checkbox"/> No <input type="checkbox"/>
CAFFEINE					Yes <input type="checkbox"/> No <input type="checkbox"/>
CIGARETTES					Yes <input type="checkbox"/> No <input type="checkbox"/>
METHADONE					Yes <input type="checkbox"/> No <input type="checkbox"/>
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes <input type="checkbox"/> No <input type="checkbox"/>
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes <input type="checkbox"/> No <input type="checkbox"/>
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes <input type="checkbox"/> No <input type="checkbox"/>
OTHER: (specify) _____ _____ _____					Yes <input type="checkbox"/> No <input type="checkbox"/>