# Westchester
## Wellness Medicine

**PATIENT MEDICAL HISTORY FORM**

Date: _____/_____/_____

Name: _____ Birthdate: _____/_____/_____
Last First M.I.

Address: _____
Street City State Zip

E-mail: _____ Phone # _____

Emergency contact: _____ Phone # _____

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Please describe the following

Sleep: _____ hrs/night

Any problems with: ❑Difficulty falling asleep ❑ Waking up in middle of night ❑ Nightmares ❑ Restless sleep

Appetite: ❑ Same as before ❑Decreased ❑Increased ❑Dieting Any weight changes: _____

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Please check all that apply:

❑ Sadness ❑ Insomnia ❑ Panic attacks ❑ Obsessions/compulsions ❑ Hopelessness ❑ Guilt

❑ Racing thoughts ❑Anxiety ❑Fatigue ❑ Withdrawal/decrease socialization ❑Decrease interest levels

❑ Irritability/easy anger ❑ Aggression ❑ Behavioral problems ❑ Impulsivity ❑Grief/loss

❑ Uncontrolled fear/phobia ❑ Nightmares ❑Recollection of Trauma ❑ Worthlessness ❑ Eating disorder

❑ Chronic pain issues ❑ General overwhelming stress ❑ Thoughts of hurting self ❑Active plan to hurt myself

❑ Hallucinations ❑ Difficulty with work/school/family ❑ Rapid weight loss/weight gain

❑ Difficulty motivating myself to do basic responsibilities ❑ Memory impairment ❑ Personality changes

❑ Mania (decrease sleep accompanied by high energy or agitation, impulsivity, increase in drive to do activity)

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**PSYCHIATRIC HISTORY**

Have you ever seen a specialist/psychiatrist? ❑ Yes ❑ No Is yes, please fill below:

| Name of Physician/Clinic | Duration of treatment | Location(City/State) | Reason for treatment |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Have you ever seen a primary care doctor for mood issues? ❑ Yes ❑ No

If so, please explain when and for what reason?

_____

_____

Have you ever been hospitalized in a psychiatric facility? ❑ Yes ❑ No If so please fill below:

| Name of Hospital | Date of hospitalization | Location(City/State) | Reason for treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

What diagnoses have you been treated for:

❑ Major depression ❑ Anxiety disorder ❑ Obsessive compulsive disorder ❑ Bipolar disorder ❑ Schizophrenia
❑ Autism ❑ Eating disorder ❑ Personality disorder ❑ ADHD/ADD ❑ Post-traumatic stress disorder
❑ Other: _____

Please check any that apply to your psychiatric history:

History of suicidal ideation: ❑ Yes ❑ No
Suicide attempts: ❑ Yes ❑ No
If above checked please specify: _____(number of suicide in lifetime)
Any hospitalization as a result? ❑ Yes ❑ No
History of aggressive/threatening behavior: ❑ Yes ❑ No
History of self-injury/cutting: ❑ Yes ❑ No
Any past history of trauma:
❑ Childhood physical abuse ❑ Childhood emotional/verbal abuse ❑ Childhood sexual abuse
❑ Childhood exposure to domestic violence ❑ Combat Trauma ❑ Witness to death of loved one
❑ Survivor of suicide ❑ Exposure to potentially deadly/deadly accident
❑ Exposure to fire ❑ Exposure to natural disaster ❑ Partner physical/emotional/verbal abuse
❑ Stranger Rape/Assault ❑ Rape/Assault by family member ❑ Exposure to war ❑ Early parental loss
❑ Neglect in childhood ❑ Forced prostitution
❑ Other: _____

## PAST MEDICAL HISTORY

Do you now or have you ever had:

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

Other medical conditions (please list):

Have you had any surgeries in the past (please list procedure and date):

## FAMILY HISTORY

| Problem | Mother | Father | Grand-mother | Grand-father | Sister | Brother | Uncle/ Aunt | Children |
|---|---|---|---|---|---|---|---|---|
| Depression | | | | | | | | |
| Anxiety | | | | | | | | |
| Obsessive compulsive | | | | | | | | |
| Anger/Aggression | | | | | | | | |
| Bipolar disorder | | | | | | | | |
| Schizophrenia | | | | | | | | |
| Completed Suicide | | | | | | | | |
| Drug Abuse | | | | | | | | |
| Dementia | | | | | | | | |
| Autism | | | | | | | | |
| Hospitalized for above | | | | | | | | |

Any of your family member have the below medical conditions:
if so please specify who below:

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

Please specify which family member has the above condition and any other conditions not listed above:

_____

_____

## SUBSTANCE ABUSE HISTORY

Are you a smoker? □ Yes □ No
If yes, how many packs do you smoke? _____ Any attempts to quit: _____
If you quit using, how long? _____

Do you consume alcohol? □ Yes □ No
How often do you drink? □ Weekly _____/wk □ Monthly _____/month □ Rarely
_____
□ Quit drinking _____(specify last usage)
Specify amount you drink in each setting: _____

Do you have a history of Substance Abuse**?** □ Yes □ No
Have you ever attended rehab? □ Yes □ No
If yes, Please state when and for treatment of what:

_____

_____

Other substances used:

| Substance | Quantity Used | Frequency of Use | Quit (Y/N) | Last Used |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes

To what medication: _____

What reaction did you have:

_____

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

| Name of drug | Dose (include dose & number of pills/day) | Length of treatment on medicine |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

Have you tried any psychiatric medications for mood/anxiety/sleep before? ❑ No ❑ Yes

If so, briefly list some you recall:

_____

_____

Was there one or more medications (including combinations) that were particularly beneficial you:

_____

## SOCIAL HISTORY

If patient is a child/adolescent:

Patient lives with/raised by : _____Any siblings:

_____

Are parents divorced? ❑ No ❑ Yes If yes specify arrangement:

_____

Any step-parents: ❑ No ❑ Yes

If patient is an adult:

Relationship Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Life/serious partner

Are you happy in your relationship: ❑ No ❑ Yes

Describe your relationship satisfaction: □ Not applicable □ Very Satisfied □ Somewhat satisfied □ Dissatisfied.

Any children: ❑ No ❑ Yes

Specify Name/Sex/Age of children below:

| Name | Son/Daughter | Biologic/Step/Adopted | Age |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Education History:

□ Currently in school: _____(specify) □ Less than a high school education
□ Graduated from high school □ GED Obtained- Specify highest grade completed: _____
□ Associates Degree □ College Degree □ Some College □ Professional Degree □ Technical Degree
□ Master's Degree

Employment status:
□ Full-time □ Part-time □ Unemployed □ Retired □ Disabled □ Homemaker

Occupation: _____ Employer: _____
How long have you had this job: _____

Any other pertinent information that you feel is important to your treatment: