Patient Clinical History

Last Name: ______________________ First Name: ______________________

Date of Birth: ______________________ Preferred language: ______________________

Race: Caucasian /African American /Hispanic /Latino/Asian/ Other : ______________________

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___ Civil Union ___

Sex: Male _______ Female _______ Do you live alone? If not, with whom? ______________________

Do you have any children: Yes ____ No ____ If yes, list ages ______________________

What is the primary reason for your visit today? ______________________

Please circle any symptoms that have been present in the last month.

Forgetfulness	Confusion	Concentration difficulties
Hearing Loss	Hallucinations	Anxiety/Fear
Depression	Restlessness	Sleep problems
Suicidal thoughts	Decreased appetite/Weight Loss	Lethargy/Low energy
Insomnia	Lack of interests	Guilt
Chest Pain	Skin Rashes	Fevers
Shortness of Breath	Vision Problems	Back Pain
Headaches	Diarrhea	Stomach Problems
Urinary Incontinence	Constipation	Dizziness

Other ______________________

PSYCHIATRIC HISTORY Yes ____ No ____ If yes, detail below:

Previous Clinicians (Name and City) ______________________

Psychiatric Hospitalizations (Name, City and Year) ______________________

____

Past Psychiatric Medications (Name and Side Effects or Benefits)

____

____

Allergies	**Reactions**
1. ______________________	______________________
2. ______________________	______________________

MEDICATIONS - List ALL prescriptions and over-the-counter medications you are taking. If this list is too lengthy, you can bring in all of your medication bottles or a typed list to include with this packet.

1. ______________________ 6. ______________________
2. ______________________ 7. ______________________
3. ______________________ 8. ______________________
4. ______________________ 9. ______________________
5. ______________________ 10. ______________________

PAST MEDICAL HISTORY - List past 3 hospitalizations

	Reason for Hospitalization	Name of Hospital	Year
1.			
2.			
3.			

MEDICAL PROBLEMS (Diabetes, Hypertension, Hepatitis, Gallstones, Ulcers, etc.)

1. ________	4. ________	7. ________
2. ________	5. ________	8. ________
3. ________	6. ________	9. ________

Do you smoke? Yes ______ No _____ If yes, how many packs per week? ______________

Do you drink alcohol? Yes ______ No _____ If yes, how many drinks per week? ______________

Do you use recreational drugs? Yes ______ No _____ If yes, which ones? ______________

Do you have a living will? Yes ______ No _____

FAMILY HISTORY

	Health Problems or Cause of Death	Alive or Age at Death
Mother		
Father		
Brothers/Sisters		
Brothers/Sisters		
Brothers/Sisters		

LEGAL HISTORY

Do you have any criminal history? Yes ____ No ____

If yes, what charges/convictions?______________________________