Addiction-Relief

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PATIENT: MEDICAL HISTORY

(To be completed by patient)

Use the opposite side of the page as necessary to complete your answers. **Please print legibly**.

Name ____

Address ____

Phone (w) ____________________ (h) ____________________ (c) ____________________

DOB ____________________ Age __________ SS# ____________________

Emergency Contact ____

Relationship to patient ____________________ Phone ____________________

Primary care physician ____________________ Phone ____________________

Date of last physical ______________ Have you ever had an EKG? ( ) N Date ______________

Current or past medical conditions (check all that apply)

( ) Asthma/respiratory
( ) Cardiovascular (heart attack, high cholesterol, angina)
( ) Hypertension
( ) Epilepsy or seizure disorder
( ) GI disease
( ) Head trauma
( ) HIV/AIDS
( ) Diabetes
( ) Liver problems
( ) Pancreatic problems
( ) Thyroid disease
( ) STDs
( ) Abnormal Pap smear
( ) Nutritional deficiency

Other (Please describe) ____

____

____

If there a family history of any of the illnesses listed above, **please put an “F” next to that illness**

MD NOTES ____

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Is there a family history of anything NOT listed here? (Please explain) ________________________________

____

____

MD NOTES ____

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Have you ever had **surgery** or been **hospitalized**? (Please describe) _______________________________

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MD NOTES ____

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Childhood Illnesses

Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? (Please describe)

____

Have you ever taken or been prescribed **antidepressants**? ( ) N For what reason ____________________

Medication(s) and dates of use ____________________________ Why stopped ____________________

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later) ______________

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Please list all current **herbal medicines**, **vitamin supplements**, etc. and how often you take them

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MD NOTES ____

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Please list any **allergies** you have (penicillin, bees, peanuts)

____

MD NOTES ____

Cigarette Smoking:
Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How many per day on average? _________ For how many years? _________

Have you ever been **treated for substance misuse**? ( ) N (Please describe when, where and for how long)

____

How long have you been **using substances?** ____

Substance Usage Overview:	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-amphetamine							
Opiates: Heroin, Methadone, Dilaudid, Oxycontin, Vicodan, Percocet, **Other?**							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills) Adderall, Ritalin, Strattera, etc.							
Tranquilizers/ Sleeping Pills							
Ecstasy							
'Benzos': Xanax, Ativan, Valium, Klonopin, etc.							

Did you ever stop using any of the above because of dependence? (   ) N (Please list) ______________________

____

____

What was your longest period of abstinence? ____

____

MD NOTES ____