ADVANCED INDIVIDUALIZED MEDICINE

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PATIENT INTAKE: MEDICAL HISTORY

Name: _____ Date: ____ /____ /_____
Address: _____
Phone: (Hm) _____ (Cell) _____ (Wk) _____
DOB: _____ Age: _____ SS#: _____

Emergency Contact: _____
Relationship to patient: _____ Phone: _____

Primary care physician (name and phone number): _____

Have you ever had an EKG? ____ Y ____ N Date: _____

Current or past medical conditions (check all that apply):
** If there is a family history of any of the illnesses listed above, please put an "F" next to that illness.**

( ) 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)
_____
_____
_____
_____

MD NOTES: _____
_____

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

MD NOTES: _____
_____

Have you ever had surgery or been hospitalized? (Please describe): _____
_____

MD NOTES: _____
_____

Childhood Illnesses:
Measles: ____ Y ____ N Mumps: ____ Y ____ N Chicken Pox: ____ Y ____ N

Have you or a family member ever been diagnosed with a psychiatric or mental illness? ____ Y ____ N

Have you ever taken or been prescribed antidepressants? ____ Y ____ N

If yes, 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).
_____
_____

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

MD NOTES:
_____
_____

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

MD NOTES:
_____
_____

Tobacco History:

Cigarettes/Cigars: Now? ____ Y ____ N In the past? ____ Y ____ N

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

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

How long have you been using substances? _____

MD NOTES: _____
_____
_____
_____

Substance Use History: ____ No ____ Yes

Past Route: How Much _____ How Often _____ Quantity _____

Date/Time of Last Use _____

MD NOTES: _____
_____

Current Uses:

____ Alcohol
____ Caffeine (pills or beverages)
____ Crystal Meth-Amphetamine
____ Cocaine
____ Heroin
____ Stimulants (pills)
____ Ecstasy
____ LSD or Hallucinogens
____ Marijuana
____ Methadone
____ Pain Killers
____ PCP
____ Tranquilizers/Sleeping Pills
____ Inhalants

Other: _____

Did you ever stop using any of the above because of dependence? ____ Yes ____ No

(Please list): _____

What was your longest period of abstinence? _____

MD NOTES: _____
_____
_____
_____
_____
_____

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

Circle one: Married Single Long-term relationship Divorced/Separated Widowed

Years married/in long-term relationship ____ Times Married ____ Times Divorced _____

Children: ____ No ____ Yes Current ages: _____

Residing with you? ____ No ____ Yes If no, where? _____

Where are you currently living? _____

Do you have family nearby? ____Yes ____ No (Please describe): _____

Education (check most recent degree):

____ Graduate School ____ College ____ Professional or Vocational School ____ High School (Grade) _____

Are you currently employed? ____ Yes ____ No

Where (if "no" where were you last employed?): _____

What type of work do/did you do? _____

How long have/did you work(ed) there? _____

Have you ever been arrested or convicted? ____ Yes ____ No

____ DWI/DUI ____ Drug-related ____ Domestic Violence ____ Other: _____

Have you ever been abused? ____ Yes ____ No

____ Physically ____ Sexually (including rape or attempted rape) ____ Verbally ____ Emotionally

Have you ever attended:

AA ____ Current ____ Past
NA ____ Current ____ Past
CA ____ Current ____ Past
ACOA ____ Current ____ Past
OA ____ Current ____ Past

If you are not currently attending meetings, what factors led you to stop? _____
_____

Have you ever been in counseling of therapy? ____ Yes ____ No

(Please describe): _____
_____

MD NOTES: _____
_____