Medical History

Name: _____ Date: _____

1. Who is your physician or the physician who sees you most often? _____

2. When was the last time you had a physical check-up? _____

3. Have you been treated by a physician or hospitalized in the last year? Yes ___ No ___

   If yes please specify: _____

4. Has there been any change in your physical health in the past year? Yes ___ No ___

   If yes please specify: _____

5. Are you taking any medication (psychiatric, non-psychiatric, over the counter) at the present time?

   Yes ___ No ___ If yes, please list (continue on the back if needed):

Medication	Dosage/Frequency	Name of Prescriber
1.		
2.		
3.		
4.		
5.		

6. Have you ever had a history of (circle all that apply):

High/ Low Blood Pressure	Diabetes	Anemia	Seizures/Epilepsy
Cardiac Problems	Asthma	Tuberculosis	Cancer (Type: _____)
Thyroid Problems	Ulcers	Tics	Other: _____

7. Are you pregnant or think you may be pregnant? Yes ___ No ___ N/A ___