PATIENT MEDICAL HISTORY

Name _____ **Age** _____ **DOB** _____ **Date**_____

Years of Education (H.S. =12) _____ **Handed:** ☐ **Left** ☐ **Right** **Gender:** ☐ **Male** ☐ **Female**

Reason for Visit _____

_____

MEDICATIONS

Medication: Dose

FAMILY HISTORY
(Relatives, Excluding Self)

Disease	No	Yes
Alzheimer's	☐	
Headache	☐	
Cancer	☐	
Epilepsy	☐	
Heart Disease	☐	
High Blood Pressure	☐	
Diabetes	☐	
Stroke	☐	
Anxiety, Depression, Panic Attacks or OCD	☐	
Problems with Attention or Learning (i.e. AHDH)	☐	
Obesity	☐	
Other	☐	

Drug / Allergies

1. _____
2. _____
3. _____
4. _____

Do you smoke? ☐ Yes ☐ No

How much? _____

Do you drink Alcohol? ☐ Yes ☐ No

How much? _____

For Women Only

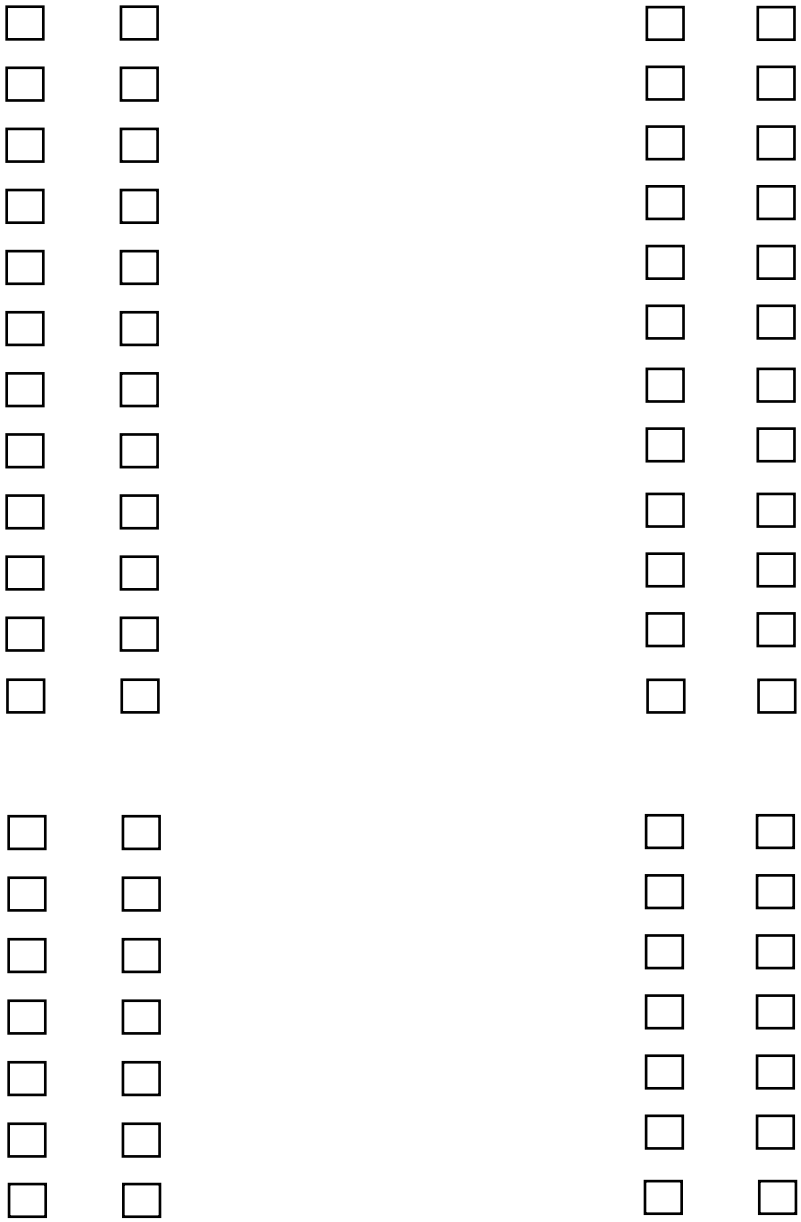
Menstrual Periods
☐ Regular ☐ irregular ☐ none

Last Menses _____

Are you taking birth control pills?
☐ Yes ☐ No

Is there a possibility you might be pregnant?
☐ Yes ☐ No

Are you trying to get pregnant?
☐ Yes ☐ No

Please Fill Out Page 2

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