

ADULT MEDICAL SCREENING

Patient Information

NAME: _____ DATE OF BIRTH: ____/____/____
SOCIAL SECURITY #: _____
Address: _____
Home phone: _____ Work phone: _____
Fax: _____ Mobile phone: _____
Occupation: _____ Email: _____
Marital Status: _____ Educational level: _____

Chief Complaint

(SPECIFY ONSET AND DURATION):

Personal Medical History

Do you receive regular medical care from a physician or clinic? NO YES
If yes, please provide the following information:
Name of physician or clinic: _____
Address: _____

CURRENT MEDICATIONS:

MEDICATION ALLERGIES: Penicillin NO YES. Other:

Have you ever had any of the following:

Birth Defects	<input type="checkbox"/> NO <input type="checkbox"/> YES	Peptic (Stomach) Ulcers	<input type="checkbox"/> NO <input type="checkbox"/> YES
Broken Bones	<input type="checkbox"/> NO <input type="checkbox"/> YES	Colitis	<input type="checkbox"/> NO <input type="checkbox"/> YES
Drug Poisoning	<input type="checkbox"/> NO <input type="checkbox"/> YES	Rheumatic Fever	<input type="checkbox"/> NO <input type="checkbox"/> YES
Injuries	<input type="checkbox"/> NO <input type="checkbox"/> YES	Tuberculosis	<input type="checkbox"/> NO <input type="checkbox"/> YES
Severe Cuts or Lacerations	<input type="checkbox"/> NO <input type="checkbox"/> YES	Gonorrhea	<input type="checkbox"/> NO <input type="checkbox"/> YES
Asthma	<input type="checkbox"/> NO <input type="checkbox"/> YES	Syphilis	<input type="checkbox"/> NO <input type="checkbox"/> YES
High Blood Pressure	<input type="checkbox"/> NO <input type="checkbox"/> YES	Meningitis or Encephalitis	<input type="checkbox"/> NO <input type="checkbox"/> YES
Diabetes	<input type="checkbox"/> NO <input type="checkbox"/> YES	Epilepsy	<input type="checkbox"/> NO <input type="checkbox"/> YES
Cancer	<input type="checkbox"/> NO <input type="checkbox"/> YES	Headaches	<input type="checkbox"/> NO <input type="checkbox"/> YES
Thyroid Disease	<input type="checkbox"/> NO <input type="checkbox"/> YES	Stroke	<input type="checkbox"/> NO <input type="checkbox"/> YES
Other Hormone Problem	<input type="checkbox"/> NO <input type="checkbox"/> YES	Head Injury	<input type="checkbox"/> NO <input type="checkbox"/> YES
Alcoholism	<input type="checkbox"/> NO <input type="checkbox"/> YES	Concussion	<input type="checkbox"/> NO <input type="checkbox"/> YES

If yes, please explain (continue on the back):

Have you had any other disease? NO YES If yes, explain:

What is your current weight (estimate if you do not know exactly)?
What is the most you have ever weighed? _____ lbs. When? _____
Can you explain any recent weight loss or weight gain?

Have you ever had to be hospitalized? NO YES If yes, complete the following:

Year	Doctor's Name	Name of Hospital

Have you ever had surgery , or been advised to have surgery? NO YES If yes, complete the following:

Year	Doctor's Name	Name of Hospital	Name of Operation or Procedure

Do you have Hay Fever or food allergies?

Have you recently had any of the following tests? When and why?

Physical Exam	<input type="checkbox"/> NO <input type="checkbox"/> YES:	
Blood Tests	<input type="checkbox"/> NO <input type="checkbox"/> YES:	
Chest X-ray	<input type="checkbox"/> NO <input type="checkbox"/> YES:	
Electrocardiogram (E KG)	<input type="checkbox"/> NO <input type="checkbox"/> YES:	
Brain Scan (MRI, CT)	<input type="checkbox"/> NO <input type="checkbox"/> YES:	
EEG	<input type="checkbox"/> NO <input type="checkbox"/> YES:	

Have you ever used the following and how much do you currently consume?

Coffee (cups/day)	<input type="checkbox"/> NO <input type="checkbox"/> YES:	Sleeping Pills	<input type="checkbox"/> NO <input type="checkbox"/> YES:
Cigarettes (packs/day)	<input type="checkbox"/> NO <input type="checkbox"/> YES:	Aspirin	<input type="checkbox"/> NO <input type="checkbox"/> YES:
Marijuana (joints/day)	<input type="checkbox"/> NO <input type="checkbox"/> YES:	Laxatives	<input type="checkbox"/> NO <input type="checkbox"/> YES:
Vitamins	<input type="checkbox"/> NO <input type="checkbox"/> YES:	Alcohol (amount and types used daily)	<input type="checkbox"/> NO <input type="checkbox"/> YES:

Have you ever used any of the following? (Circle the ones used)

Celexa	Prozac	Luvox	Paxil	Zoloft
Wellbutrin	Remeron	Serzone	Effexor	Lexapro
Buspar	Dilantin	Tegretol	L-Dopa	Cogentin
Lithium	Depakote	Topamax	Neurontin	Lamictal
Valium	Librium	Tranxene	Dalmane	Klonopin
Ativan	Restoril	Xanax	Serax	Halcion
Anafranil	Sinequan	Tofranil	Elavil	Pamelor
Haldol	Prolixin	Trilafon	Navane	Stelazine
Orap	Loxitane	Moban		
Thorazine	Mellaril	Serentil		
Zyprexa	Risperdal	Seroquel	Geodon	Clozaril
Abilify	Phenobarbital	Other barbiturates:		
Amphetamines	Ritalin	Dexedrine	Other stimulants:	
Heroin	Codeine	Methadone	Percodan	Dilaudid
Talwin	Darvon	Demerol		
Quaaludes	Ambien	Sonata	Other sedatives:	
Cocaine	Glue/inhalants			

Please detail periods of use, dosages, reasons for use, and reason for discontinuation of the above (continue on reverse).

Personal Psychiatric History

Have you ever received any previous psychiatric or psychological evaluation or treatment? NO YES If yes, complete the following (continue on back):

Year	Doctor	Clinic or Hospital	Reason	Medication Used (if any)
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Have you ever attempted suicide? NO YES If yes, please describe when, how, what happened?

Family History

Please describe any family history of medical illnesses (such as cancer, hypertension, diabetes, neurological disorders):

Please describe any family history of mental health problems, such as depression, manic-depression (bipolar), anxiety, schizophrenia, suicides, substance use, learning disorders, autism:

Review of Your Current Health

Do you have any of the following? (Please circle)

Unusual excessive thirst	Change in appetite or eating habits
Weight loss or weight gain	Skin problem
Weakness or tiredness	Urine problems, blood in urine
Thyroid problem, goiter	Joint pain
Shortness of breath at night or with exercise	Lumps anywhere
Cough or wheeze	Double vision or poor vision
Chest pain	Difficulty hearing
Palpitation or heart fluttering	Fainting spells / blackout spells
Swelling of hands or feet	Convulsion
Indigestion, gas, heartburn	Trouble sleeping
Spitting up blood	Sexual problems
Vomiting / vomiting blood	Depression
Stomach pain or stomach ulcer	Problems with memory, thinking, or concentration
Diarrhea	Suicidal thoughts
Constipation	Auditory hallucinations
Blood in stool	Visual hallucinations

Please describe on the reverse any of the positive answers above.

FOR WOMEN ONLY:

Date your last menstrual period began:	Number of pregnancies:
Number of children born alive:	Number of therapeutic abortions: .
Number of miscarriages or stillbirths:	Have you had a Pap smear within the last year? <input type="checkbox"/> NO <input type="checkbox"/> YES
Do you use any contraceptive method? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, which?	
Do you examine your breasts for lumps? <input type="checkbox"/> NO <input type="checkbox"/> YES	

PATIENT'S SIGNATURE: _____

DATE: ____/____/____