Superior Health and Wellness

"Personalized care for you"

MEDICAL HISTORY FORM

Date: _____/_____/_____ Birthdate: _____/_____/_____

NAME: _____
Last First M. I.

Age: Sex: _____ Gender:_____ Preference:_____ Weight:_____ Height: _____

How did you hear about Superior Health and Wellness Group?

Describe briefly your present symptoms:

Please list your primary care physician and specialists that you currently see: (include their name & location):

Please list any medical hospitalizations (include where, when, & for what reason):

Please list any psychiatric hospitalizations/partial hospitalization programs/respites (include where, when, & for what reason):

Have you had psychotherapy or are you currently in psychotherapy? (include where, when & therapist's name):

Have you ever struggled with Eating or Body Image? ❑ Yes ❑ No If so, please check all that apply:

Restricting Binging Purging Over Exercise Chewing and spitting out food

Laxative Use Food Avoidance Fear of Certain Foods Body Checking Fear of looking at mirror

Readjusting clothes throughout the day Difficulty leaving the home d/t appearance Frequent changing clothes

DRUG ALLERGIES
Do you have any drug allergies? ❑ Yes ❑ No Please list any drug allergies, reactions and age of onset:

CURRENT MEDICATIONS		
Please list any medications that you are now taking. Include non-prescription or over the counter medications & vitamins or supplements:		
Name of Drug:	**Dose (including how many times per day):**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PAST PSYCHIATRIC MEDICATIONS		
Please list any psychiatric medications that you took in the past.		
Name of drug	**How long did you take it?**	**Please list side effects:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

Past Surgical History:

Please list all surgeries, dates and locations:

REPRODUCTIVE/SEXUAL HISTORY:

Females Only:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Do you have regular periods? ❑ Yes ❑ No

Have you reached menopause? ❑ Yes ❑ No At what age?

For Everyone:

Do you struggle with Infertility ❑ Yes ❑ No If yes, please describe:

Are you currently being treated with hormone replacement therapy? ❑ Yes ❑ No If yes, please describe:

Have you ever had Gender Reassignment Surgery (GRS)? ❑ Yes ❑ No
If yes, please circle: male to female or female to male?

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; amount ___
- ❑ Recent weight loss: amount___
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Intrusive thoughts
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

FEMALE ONLY:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

OTHER PROBLEMS:

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ❑ Yes ❑ No Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Who do you live with?

Do you have any children? ❑ Yes ❑ No Ages?
Do you have any pets? ❑ Yes ❑ No

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:
Maternal Relatives:

Paternal Relatives:

SUBSTANCE USE

DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes □ No □
CANNABIS: Marijuana, oil, lotion					Yes □ No □
STIMULANTS: Cocaine, crack					Yes □ No □
STIMULANTS: Methamphetamine—speed					Yes □ No □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Dexedrine					Yes □ No □
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, Ativan, Klonopin					Yes □ No □
SEDATIVES/HYPNOTICS/BARBITURATES: Phenobarbital					Yes □ No □
HEROIN					Yes □ No □
STREET OR ILLICIT METHADONE					Yes □ No □
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes □ No □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes □ No □
INHALANTS: Glue, gasoline, aerosols, paint thinner					Yes □ No □
OTHER: (specify) _____ _____ _____					Yes □ No □