S | P | A
SOUTHAMPTON
psychiatricassociates

PATIENT MEDICAL HISTORY FORM

NAME _____ DATE _____

OCCUPATION _____ BIRTHDATE ___ / ___ / ___ AGE _____ GENDER ☐ MALE ☐ FEMALE

ALLERGIES TO MEDICATIONS, X-RAYS, DYES OR OTHER SUBSTANCES: _____

_____

☐ NONE

CURRENT MEDICATIONS, VITAMINS, SUPPLEMENTS, HERBS – PRESCRIPTION AND OVER-THE-COUNTER

(LIST NAME AND DOSE): ☐NONE

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY AND REVIEW OF SYMPTOMS

☐ High Blood Pressure	☐ Bronchitis	☐ Change in bowel habits	☐ Arthritis	☐ Skin Diseases
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight loss/gain	☐ Osteoporosis	☐ Asthma
☐ Cancer	☐ Persistent cough	☐ Hemorrhoids	☐ Low back problems	☐ Blood in stool
☐ Anemia	☐ T.B.	☐ Gall bladder disease	☐ Numbness of arms/legs	☐ Anxiety
☐ Heart disease	☐ Hay fever	☐ Colitis	☐ Headache	☐ Depression
☐ Chest Pain/tightness	☐ Abdominal discomfort	☐ Bruise easily	☐ Kidney disease	☐ Alcohol abuse
☐ Shortness of Breath	☐ Indigestion	☐ Thyroid disease	☐ Kidney Stones	☐ Drug Abuse
☐ Swollen ankles	☐ Nausea/Vomiting	☐ Head or neck radiation	☐ Difficulty Passing urine	☐ Gout
☐ Palpitations	☐ Diarrhea	☐ Lightheadedness	☐ Difficulty holding urine	☐ Ulcers
☐ Rheumatic fever	☐ Constipation	☐ Frequent urination	☐ Sleep problems	
☐ Hepatitis	☐ Sexually transmitted disease	☐ Blood disorders		

GYNECOLOGIC AND OBSTETRIC HISTORY: WOMEN ONLY

Age at onset of periods: _____ Pregnancies: _____

Last menstrual period: _____ Births: _____

Frequency: _____ Miscarriages: _____

OPERATIONS & HOSPITALIZATIONS (LIST YEAR AND TYPE OF OPERATION OR DIAGNOSES AFTER HOSPITALIZATION)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

NAME _____ DATE _____

IMMUNIZATION HISTORY	YEAR	OTHER VACINES	YEAR
Last Tetanus Shot?	_____	Lyme Vaccine?	_____
Pneumovax Shot?	_____	Hepatitis A Vaccine?	_____
Flu Shot?	_____		
Hepatitis B Vaccine?	_____		

SCREENING TESTS (LAST ONE)	YEAR		YEAR
Mammogram?	_____	Breast exam?	_____
Pap Smear?	_____	Cholesterol Check?	_____
Stool check for blood?	_____	Prostate Exam?	_____

FAMILY HISTORY

ILLNESS	GRAND FATHER	GRAND MOTHER	FATHER	MOTHER	BROTHER	SISTER	CHILD	AGES WHEN DIAGNOSED
Cancer (type)								
Hypertension								
Diabetes								
Stroke								
Mental Disease (anxiety, depression)								
Drug or Alcohol addiction								
Glaucoma								
Bleeding diseases								
Other:								

PREVENTION

Do you wear seat belts?	☐Yes	☐No	Women: Do you perform self breast exams?	☐Yes	☐No
Do you wear a bike helmet?	☐Yes	☐No	Men: Do you perform self testicular exams?	☐Yes	☐No
Do you smoke? Amount: _____	☐Yes	☐No	Do you exercise regularly?	☐Yes	☐No
Do you drink alcohol beverages?	☐Yes	☐No	Are you following a specific diet?	☐Yes	☐No
Do you drink coffee? Amount: _____	☐Yes	☐No	If so, type of diet: _____		
Do you drink tea?	☐Yes	☐No	Do you ever feel afraid of your partner?	☐Yes	☐No
Is there a gun in your home?	☐Yes	☐No	Do you have a living will?	☐Yes	☐No
Do you use drugs? Type: _____	☐Yes	☐No	Do you have a donor card?	☐Yes	☐No

Have you ever engaged in any activity which would put you at risk of AIDS? ..... ☐Yes ☐No

Have you ever worked with chemicals, paints, asbestos or other hazardous material?..... ☐Yes ☐No