



NEW PATIENT MEDICAL HISTORY  
BEHAVIORAL HEALTH

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*Please provide as much detail as you are able so that we can give you the safest and best care possible.*

Preferred Pharmacy (name and location): \_\_\_\_\_

Primary Care Provider

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

**ALLERGIES**

**No Known Allergies** List any allergies and intolerances to **medications, food or the environment.**

| Allergy | Reaction |
|---------|----------|
|         |          |
|         |          |
|         |          |

**MEDICATIONS**

**No Medications** List any medications you are taking, with dose and how often.

| Medication Name | Dose | How often? |
|-----------------|------|------------|
|                 |      |            |
|                 |      |            |
|                 |      |            |
|                 |      |            |
|                 |      |            |

List any Vitamins, Supplements and Over the Counter Medicines

|    |    |
|----|----|
| 1. | 2. |
| 3. | 4. |
| 5. | 6. |

**DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD**



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**MEDICAL / PSYCHIATRIC HISTORY**

What **medical** problems have you had? Please mark **all** that apply:

| CONDITION  | CONDITION  | CONDITION                                 | CONDITION                             |
|--|--|---|---------------------------------------|
| ADD/ADHD   | Bronchitis                                       | Intermittent Explosive Disorder           | Post-traumatic Stress Disorder (PTSD) |
| Abdominal pain                                   | Circadian rhythm disorder (sleep phase syndrome) | Major Depression-chronic                  | Prematurity                           |
| Acne   | Chickenpox                                       | Major Depression-single episode           | Psychotic Disorder                    |
| Adjusted disorder with anxiety                   | Concussion/CHI                                   | Menstrual Problems                        | Pyelonephritis                        |
| Adjusted disorder with conduct disorder          | Congenital Heart Disease                         | Migraines                                 | Recurrent Depression<br>Psychosis     |
| Adjustment disorder with depression              | Constipation                                     | Mood Disorder                             | Recurrent Otis Media                  |
| Adjustment disorder with disturbance of emotions | Depression                                       | Narcolepsy                                | Schizoaffective Disorder              |
| Allergic rhinitis                                | Diabetes   | Obsessive Compulsive Disorder             | Seizure Disorder                      |
| Allergies  | Drug Dependence                                  | Oppositional Defiant Disorder             | Seizure-Febrile                       |
| Anemia   | Dysthymic Disorder                               | Panic Disorder w/ agoraphobia             | Sleep apnea                           |
| Anxiety  | Eczema   | Panic Disorder w/o agoraphobia            | Social Phobia                         |
| Bipolar I  | Fracture   | Paranoid Schizophrenia                    | Substance Dependence                  |
| Bipolar II                                       | G.E.R.D.   | Parasomnias<br>REM _____<br>Non REM _____ | Suicidality                           |
| Bleeding Disorder                                | Headache, migraine                               |   | Traumatic brain injury                |
| Borderline Personality Disorder                  | Hearing Problems                                 | Pneumonia                                 | Urinary tract infection               |
| Bronchiolitis                                    | Heart murmur                                     | Poly-substance Dependence                 | Other:<br>_____                       |

**Other medical problems:** \_\_\_\_\_

**SURGICAL HISTORY**

What **surgeries** have you had? Please mark **all** that apply and include the year they were performed.

|                |                        |                         |
|----------------|------------------------|-------------------------|
| Adenoidectomy  | Hypospadias repair     | Tonsillectomy           |
| Appendectomy   | Inguinal hernia repair | Umbilical hernia repair |
| Circumcision   | Lymph node biopsy      |                         |
| Dental surgery | PET placement          |                         |

**Other surgeries:** \_\_\_\_\_

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FAMILY HISTORY

List health conditions for each family member.

|                      | Alive | Deceased | Age of Death | Health Condition(s) |
|----------------------|-------|----------|--------------|---------------------|
| Father               |       |          |              |                     |
| Mother               |       |          |              |                     |
| Paternal Grandmother |       |          |              |                     |
| Paternal Grandfather |       |          |              |                     |
| Maternal Grandmother |       |          |              |                     |
| Maternal Grandfather |       |          |              |                     |
| Brother              |       |          |              |                     |
| Sister               |       |          |              |                     |

SOCIAL HISTORY

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

(For patients 12 and older)

Tobacco/smoking status: Never \_\_\_\_\_  
 Current \_\_\_\_\_ Type \_\_\_\_\_ Amount \_\_\_\_\_ Duration \_\_\_\_\_  
 Former \_\_\_\_\_ Type \_\_\_\_\_ Amount \_\_\_\_\_ Duration \_\_\_\_\_

Tobacco use in the household?  Yes  No  
 Do you use alcohol?  Yes  No Type \_\_\_\_\_ Amount \_\_\_\_\_ Frequency \_\_\_\_\_  
 Alcohol use in the household?  Yes  No  
 Do you use recreational drugs?  Yes  No Type \_\_\_\_\_ Amount \_\_\_\_\_ Frequency \_\_\_\_\_  
 Substance abuse use in the household?  Yes  No

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

(For patients under 12)

Tobacco use in the household?  Yes  No  
 Alcohol use in the household?  Yes  No  
 Substance abuse use in the household?  Yes  No

HOME ENVIRONMENT

Child lives with: \_\_\_\_\_

EXERCISE

Do you exercise?  Yes  No If yes, list type of exercise and number of times/week: \_\_\_\_\_

EMPLOYMENT/SCHOOL

Grade in school: \_\_\_\_\_ Name of school: \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_

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**REVIEW OF SYSTEMS**

| CONSTITUTIONAL             |     |    | CARDIOVASCULAR            |     |    | NEUROLOGICAL                    |     |    |
|----------------------------|-----|----|---------------------------|-----|----|---------------------------------|-----|----|
| Headaches                  | Yes | No | Heart trouble             | Yes | No | Frequent or recurring headaches | Yes | No |
| Recent weight gain         | Yes | No | Palpitations              | Yes | No | Head injury                     | Yes | No |
| Recent weight loss         | Yes | No | Sudden heart beat changes | Yes | No | Stroke                          | Yes | No |
| EYES                       |     |    | RESPIRATORY               |     |    | Tremors                         | Yes | No |
| Eye disease/injury         | Yes | No | Asthma                    | Yes | No | PSYCHIATRIC                     |     |    |
| Glaucoma                   | Yes | No | COPD                      | Yes | No | Depression                      | Yes | No |
| ENT                        |     |    | Use oxygen                | Yes | No | Memory loss or confusion        | Yes | No |
| Hearing loss               | Yes | No | Wheezing                  | Yes | No | Nervousness                     | Yes | No |
| GENITOURINARY              |     |    | GASTROINTESTINAL          |     |    | Sleep problems                  | Yes | No |
| Frequent urination         | Yes | No | Gastroesophageal reflux   | Yes | No | ENDOCRINE                       |     |    |
| Incontinence or dribbling  | Yes | No | Loss of appetite          | Yes | No | Glandular/hormone problem       | Yes | No |
| Sexual difficulty          | Yes | No | Nausea/Vomiting           | Yes | No | Thyroid disease                 | Yes | No |
| MUSCULOSKELETAL            |     |    | HEMATOLOGIC               |     |    |                                 |     |    |
| Back pain                  | Yes | No |                           |     |    | Easily bruised/bleed            | Yes | No |
| Difficulty walking         | Yes | No |                           |     |    |                                 |     |    |
| Weakness of muscles/joints | Yes | No |                           |     |    |                                 |     |    |

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