Forest View Medication Management Clinic

Personal Medical History

Patient Name: _____ **Date of Birth:** _____

Please check **ALL** that apply, and provide appropriate details:

	PATIENT History	Details/Explain:
☐	Arthritis	
☐	Asthma	
☐	Cancer	
☐	Chronic Pain	
☐	Diabetes	
☐	Digestive problems	
☐	Heart Disease	
☐	High Blood Pressure	
☐	High Cholesterol	
☐	Immune Compromised	
☐	Seizures	
☐	Other:	
☐	None	

	FAMILY History	Family Member/Details:
☐	Arthritis	
☐	Asthma	
☐	Cancer	
☐	Chronic Pain	
☐	Diabetes	
☐	Digestive problems	
☐	Heart Disease	
☐	High Blood Pressure	
☐	High Cholesterol	
☐	Immune Compromised	
☐	Seizures	
☐	Other:	
☐	None	

ALLERGIES

List all allergies to medications, foods and other items

_____

_____ ☐ None

Surgical/Invasive Procedure History	
Date/Year:	Details:
☐ None	

Hospitalization History	
Date/Year:	Details:
☐ None	

For Children/Adolescents Only: please check **ALL** that apply during pregnancy for the patient:

☐	Mother took prescribed drugs	☐	Mother had health problems	☐	Mother drank alcohol
☐	Mother took street drugs	☐	Trauma to the child at birth	☐	Child born with birth defects or addictions

Explain: _____

☐ Unable to provide/obtain information: ☐ adoption ☐ guardian ☐ other _____

Patient Name: _____ **Date of Birth:** _____

Please list *any and all* medications and supplements you are currently taking for any reason:

Current Medications: Prescribed & Over-the-Counter	
Medication:	Details:
☐ None	

Vitamins, Supplements, Herbs/Herbal Remedies	
Medication:	Details:
☐ None	

HABITS	
Use of:	Amount/Frequency/Details:
Alcohol	☐ None
Caffeine	☐ None
Exercise	☐ None
Special Diet	☐ None
Street Drugs	☐ None
Tobacco	☐ None

When was your last complete physical?
☐ Inpatient ☐ Other: _____

Have you had a weight gain/loss of 10 lbs or more within the last 30 days?
☐ No ☐ Yes: _____

Have you ever in your life attempted suicide? ☐ No
☐ Yes (when/how?): _____

_____

For Women Only:
Last Menstrual Period: _____ Are you Pregnant? ___
Due Date? _____ Currently taking Birth Control?
☐ No ☐ Yes: _____

Do you have a Primary Care Physician? ☐ No ☐ Yes

_____
Physician's Name

Do you have an outpatient therapist/counselor? ☐ No ☐ Yes

_____
Counselor's Name

Do you see a Nutritionist?
☐ **No** ☐ Yes

_____
Clinician's Name

To the best of my knowledge, the information I provided is accurate.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

CLINICIAN RECOMMENDATIONS: _____

_____ ☐ None

CONFIDENTIAL INFORMATION: Any further release of this document without additional authorization by the patient will be a breach of confidentiality. Federal Regulation (2 CFP, Part 2) and State Laws (P.A. 258, Chapter 7, Section 748)

_____ _____
Clinician Signature Date