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Print Form

2100 Sawtelle Blvd., Suite #107, Los Angeles, CA 90025

Adult Medical Screening

Patient Information

NAME _____ DATE of BIRTH _____

SOCIAL SECURITY # _____

ADDRESS _____

TELEPHONE: *Home* _____ *Work* _____ *Fax* _____

Mobile _____ Email _____

Occupation _____

Marital Status _____ Education 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:*

Name of physician or clinic _____

Address _____

CURRENT MEDICATIONS (specify dosage, route, frequency, reason for prescription, and duration of treatment)

MEDICATION ALLERGIES: Penicillin ◯ *No* ◯ *Yes*

Other _____

Have you ever had any of the following? *(check all that apply)*

☐ Birth Defects	☐ Severe Cuts or Lacerations	☐ Alcoholism	☐ Tuberculosis	☐ Epilepsy
☐ Broken Bones	☐ High Blood Pressure	☐ Cancer	☐ Gonorrhea	☐ Headaches
☐ Drug Poisoning	☐ Diabetes	☐ Peptic (Stomach) Ulcers	☐ Syphilis	☐ Stroke
☐ Injuries	☐ Thyroid Disease	☐ Colitis	☐ Meningitis	☐ Head Injury
☐ Asthma	☐ Other Hormone Problem	☐ Rheumatic Fever	☐ Encephalitis	☐ Concussion

Please explain checked items

Have you had any other disease? ◯ *No* ◯ *Yes* *If yes, please explain*

What is your current weight? *(estimate if you do not know exactly)*

What is the most you have ever weighed? When?

Can you explain any recent weight loss or weight gain?

Have you ever had to be hospitalized? ◯ *No* ◯ *Yes* *If yes, please 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, please complete the following:*

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

Have you ever had hay fever? ◯ *No* ◯ *Yes*

Have you ever had food allergies? ◯ *No* ◯ *Yes* *If yes, please describe*

Have you recently had any of the following tests? If yes, when and why?

☐ Physical Exam	Date		Purpose	
☐ Blood Tests	Date		Purpose	
☐ Chest X-ray	Date		Purpose	
☐ Electrocardiogram (EKG)	Date		Purpose	
☐ Brain Scan (MRI, CT)	Date		Purpose	
☐ EEG	Date		Purpose	

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

☐ Coffee (cups/day)		☐ Sleeping Pills	
☐ Cigarettes (packs/day)		☐ Aspirin	
☐ Marijuana (joints/day)		☐ Laxatives	
☐ Vitamins		☐ Alcohol *See below*	

Amount and types of alcohol used daily

Have you ever used any of the following? *(check all that apply)*

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

☐ Other prescription drugs and over-the-counter medications:

Please detail periods of use, dosages, reasons for use and reason for discontinuation of checked items above

Personal Psychiatric History

Have you ever received any previous psychiatric or psychological evaluation or treatment? ◯ *No* ◯ *Yes* *If yes, please provide the following:*

Year	Doctor	Clinic or Hospital	Reason	Medication Used (if any)

Have you ever attempted suicide? ◯ *No* ◯ *Yes* If yes, please describe when, how, and what happened.

Family History

Please describe any family history of medical illnesses (including your first and second degree relatives).

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? *(check all that apply)*

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

Please describe any of the checked items 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? ◯ *No* ◯ *Yes*

Do you use any contraceptive method? ◯ *No* ◯ *Yes* If yes, which? _____

Do you examine your breasts for lumps? ◯ *No* ◯ *Yes*

PATIENT'S SIGNATURE _____ Date _____