

Peter M. Levine, M.D., LLC
Patient Medical History Form

Today's Date ____/____/____

Name _____

Date of Birth ____/____/____ Age _____ Sex ____Female ____ Male

Who referred you to this practice? _____

Describe briefly your present symptom(s)/problem(s): _____

Please list other practitioners you have seen for this problem (if anyone): _____

Please provide details regarding any outpatient psychiatric treatment/psychotherapy you may have had in the past. _____

Are you currently in treatment with a mental health professional? _____

Psychiatric Hospitalizations (include where, when, for what reason & psychiatric diagnosis)

Have you ever had ECT? _____

CURRENT MEDICATIONS

Drug Allergies: ____Yes ____No To What? _____

Please list any medications that you are now taking. Include non-prescription medications and vitamins or supplements.

Name of Drug Dose (strength & number of pills per day) How long have you been taking this?

PAST MEDICAL HISTORY

Do you now or have you ever had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> High blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | | |

Other Medical Conditions (please list)

Personal History

Were there problems with your birth? _____

Where were you born and 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

Religious preference, if any _____

What is your current or past occupation? _____

Are you currently working? Yes No Hours/week _____

If not, are you: Retired Disabled Sick Leave

Do you receive disability or SSI? Yes No

If yes, for what disability and how long? _____

Have you ever had legal problems? (specify)

Family History

	If Living		If Deceased	
	Age	Health & Psychiatric	Age at death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____

Extended Family Psychiatric Problems Past & Present:

Maternal Relatives _____

Paternal Relatives _____

SYSTEMS REVIEW

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

GENERAL

- Recent weight gain, how much ___
- Recent weight loss, how much ___
- Fatigue
- Weakness
- Fever
- Night sweats

MUSCLE/JOINTS/BONES

- Numbness
 - Joint Pain
 - Muscle weakness
 - Joint swelling
- Where? _____

EARS

- Ringing in ears
- Loss of hearing

EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

THROAT

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

HEART & LUNGS

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

WOMEN'S REPRODUCTIVE HISTORY

- Age of first period: _____
- Number of pregnancies: _____
- Number of miscarriages: _____
- Number of abortions: _____
- Have you reached menopause? Yes No At what age? _____
- Do you have regular periods? Yes No

NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

STOMACH/INTESTINES

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

SKIN

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

BLOOD

- Anemia
- Clots

KIDNEY/URINE/BLADDER

- Frequent or painful urination
- Blood in urine

WOMEN ONLY

- Abnormal pap smear
- Irregular periods
- Bleeding between periods
- PMS

PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulties with sexual arousal
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide/attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid Speech
- Guilty thoughts
- Paranoia
- Mood Swings
- Anxiety
- Risky behavior

OTHER PROBLEMS

SUBSTANCE USE

Drug Category <i>(circle each substance used)</i>	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: <i>Marijuana, hashish, hash oil</i>					YES NO
STIMULANTS: <i>Cocaine, crack</i>					YES NO
STIMULANTS: <i>Methamphetamine-speed, ice, crack</i>					YES NO
AMPHETAMINES/OTHER STIMULANTS: <i>Ritalin, Benzedrine, Dexedrine</i>					YES NO
BENZODIAZEPHINES/TRANQUILIZERS: <i>Valium, Librium, Halcion, Xanax Diazepam, "Roofies"</i>					YES NO
SEDATIVES/HYPNOTICS/BARBITURATES: <i>Amytal, Seconal, Dalmane, Quaalude, Phenobarbital</i>					YES NO
HEROIN					YES NO
STREET OR ILLICIT METHADONE					YES NO
OTHER OPIOIDS: <i>Tylenol #2 & #3, 282's, 292's, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid</i>					YES NO
HALLUCINOGENS: <i>LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide)</i>					YES NO
INHALANTS: <i>Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room</i>					YES NO
OTHER: <i>Specify _____</i>					YES NO