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:

___Diabetes
___High blood Pressure
___High cholesterol
___Hypothyroidism
___Goiter
___Cancer (type)_______________
___Leukemia
___Psoriasis
___Angina
___Heart problems
___Heart Murmur
___Pneumonia
___Pulmonary embolism
___Asthma
___Emphysema
___Stroke
___Epilepsy (seizures)
___Cataracts
___Kidney disease
___Crohn's Disease
___Colitis
___Anemia
___Jaundice
___Hepatitis
___Stomach or peptic ulcer
___Rheumatic fever
___Tuberculosis
___HIV/AIDS

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

NERVOUS SYSTEM
__Headaches
__Dizziness
__Fainting of 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
____
____
____

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

SUBSTANCE USE

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