BIO-BEHAVIORAL MEDICAL CLINICS, INC.

Medical History

Name: _____ Age: _____ Date of Birth: _____

Primary Physician: _____

Last Medical Exam: _____

List all medications you are currently taking and doses, if known:

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Who prescribed the medications? _____

PHARMACY INFORMATION:

Pharmacy Name: _____

Pharmacy Address: _____ Cross Streets: _____

Zip Code: _____ Pharmacy Phone: _____

List any medical problems you are currently experiencing: _____

_____

Have you been seen by a physician for these problems? ☐ Yes ☐ No

If YES, by whom? _____

Have you received psychiatric help or counseling of any kind before? ☐ Yes ☐ No

If yes, when, and please explain the nature of your consultation: _____

_____

_____

Have you received treatment for alcohol or drug abuse/dependence? ☐ Yes ☐ No

If yes, when, and please explain the nature of your treatment, including current status: _____

_____

_____

Is your visit today court ordered? ☐ Yes ☐ No If yes, please provide details:

_____

_____

Is your visit today work-related? ☐ Yes ☐ No

Please see back page

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Please check any of the following problems which may pertain to you:

- ☐ Alcohol Use/Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Anger Management
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Change in Appetite
- ☐ CHF
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Cutting
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Drug Use/Abuse
- ☐ Dysfunctional Relationship
- ☐ Eating Problems
- ☐ Emphysema
- ☐ GERD
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Heart Murmur
- ☐ History of Physical Abuse/Assault
- ☐ History of Sexual Abuse/Assault
- ☐ History of Suicide Attempts
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Internet/Gaming Problems
- ☐ Kidney Disease
- ☐ Lack of Concentration
- ☐ Lack of Energy
- ☐ Loneliness
- ☐ Marital/Family Problems
- ☐ Migraine Headache
- ☐ Myocardial Infraction
- ☐ Obesity
- ☐ Pain
- ☐ Panic Attacks
- ☐ Pornography Problems
- ☐ Seizures
- ☐ Sexual Problems
- ☐ Shyness
- ☐ Sickle Cell Anemia
- ☐ Sleeping Difficulty
- ☐ Stroke
- ☐ Suicide Attempts
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Trauma/Violence
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: _____

Any surgical history? ☐ Yes ☐ No If yes, please provide details:

_____

_____

_____

Has your child ever had a problem with:

- ☐ Alcohol
- ☐ Bedwetting
- ☐ Cruel to Animals
- ☐ Crying
- ☐ Cutting
- ☐ Drugs
- ☐ Excessively Shy
- ☐ Head Banging
- ☐ History of Suicide Attempts
- ☐ Hyperactivity
- ☐ Insomnia/Unable to sleep
- ☐ Lying
- ☐ Nail Biting
- ☐ Nightmares
- ☐ Phobias/Fears
- ☐ Police Problems
- ☐ Running Away from Home
- ☐ School Problems
- ☐ Setting Fires
- ☐ Sex Problems
- ☐ Sleepwalking
- ☐ Soiling Pants
- ☐ Stealing
- ☐ Temper Tantrums
- ☐ Thumb sucking
- ☐ Truancy

Other: _____

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Medical History

Family History (THIS PORTION IS NOT FILLABLE. PLEASE, CHECK THE APPROPRIATE BOXES WITH A PEN)

	Adopted	Alcohol Abuse	Arthritis	Asthma	Birth	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	High Cholesterol	History Unknown	Hypertension	Kidney Disease	Learning	Mental Illness	Miscarriages	Stroke	Tobacco Use	Vision Loss
Mother																					
Father																					
Sibling 1																					
Sibling 2																					
Sibling 3																					
Maternal Grandma																					
Maternal Grandpa																					
Paternal Grandma																					
Paternal Grandpa																					

Social History *(PLEASE CHECK ALL THAT APPLY)*

Current Alcohol Use

☐ Yes ☐ No Number of daily drink _____ Number of weekly drink _____

Comments: _____

Current Drug Use

☐ Yes ☐ No

Number of times per week _____

Types: ☐ Marijuana ☐ Methamphetamines ☐ Cocaine ☐ IV ☐ Other: _____

Comments: _____

Tobacco Use

☐ Yes ☐ No

Years: ☐ 1 year < ☐ 2-5 years ☐ 5-10 year ☐ 10 years or more

Packs a day ☐ ¼ pack ☐ ½ pack ☐ 1 pack

Please see back page

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Smokeless Tobacco ☐ Yes ☐ No

Ready to quit ☐ Yes ☐ No

Comments: _____

Overall Health

How would you describe your health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Depression Screening

☐ Yes ☐ No Over the past 2 weeks, have you felt down, depressed or hopeless?

☐ Yes ☐ No Over the past 2 weeks, have you felt little interest or pleasure in doing things?

Social/Emotional Support

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

General Life Satisfaction

In general, how satisfied are you with your life?

☐ Very Satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied

High Stress

How often is stress a problem for you?

☐ Never/Rarely ☐ Sometimes ☐ Often ☐ Always

How well do you cope with the stress in your life?

☐ Effectively ☐ Sometimes have problems ☐ Often have problems

Pain/Fatigue

How often is pain a problem for you?

☐ Never/Rarely ☐ Sometimes ☐ Often ☐ Always

How often is fatigue a problem for you?

☐ Never/Rarely ☐ Sometimes ☐ Often ☐ Always

_____ _____

Patient name Date

_____

Patient Signature