Catherine Kaplan, Ph.D., LLC

PATIENT MEDICAL HISTORY FORM (rev 01/17)

NAME: _____ DATE: _____

OCCUPATION: _____BIRTHDATE: _____

AGE: _____ GENDER: M F

_____NO KNOWN DRUG ALLERGIES / PLEASE LIST ALLERGIES TO MEDICATIONS, X-RAYS, DYES OR OTHER SUBSTANCES: _____

CURRENT MEDICAL DIAGNOSES: _____

_____

CURRENT MEDICATIONS: _____ NO CURRENT MEDICATIONS
LIST MEDICINE AND DOSE:

_____

_____

_____

When was your last Physical Exam? _____

Completed by whom: _____

Type of doctor: Primary care or specialist?_____

PAST MEDICAL HISTORY AND REVIEW OF SYMPTOMS:

____High blood pressure
____Diabetes
____Cancer
____Anemia
____Heart Disease
____Chest Pain/Tightness
____Shortness of Breath
____Unexplained weight loss/gain
____Palpitations
____Thyroid Disease
____Hepatitis
____Bronchitis
____Pneumonia
____Persistent Cough
____T.B.
____Hay Fever
____Abdominal Discomfort
____Indigestion
____Depression
____Nausea/Vomiting
____Diarrhea
____Constipation
____Sexually Transmitted Disease
____Lightheaded
____Numbness of arms/legs
____headaches
____Sleep problem
____Asthma
____Anxiety
____Alcohol Abuse
____Drug Abuse

HOSPITALIZATIONS &/OR OPERATIONS: (List year and type of operation OR diagnosis after hospitalization)

FAMILY HISTORY:

Please list any major diseases that have been in your family and person with illness:

Any family history of mental health issues / who

Any family history of Drug or Alcohol Addiction

PREVENTION:

Do you wear seat belts? Y N

Do you wear a bike helmet? Y N

Do you drink coffee? Y N

Amount: _____

Do you drink tea? Y N

Amount: _____

Do you exercise regularly? Y N

Do you smoke? Y N

Amount: _____

Do you drink alcohol? Y N

Are you following a specific diet Y N

Type of diet? _____

Is there a gun in your house? Y N

Do you ever feel afraid of your partner? Y N

FOR WOMEN ONLY:

GYNECOLOGICAL AND OBSTETRIC HISTORY:

Age at onset of periods: _____

Last menstrual period: _____

Frequency of menstrual cycle: _____

Pregnancies: _____

Births: _____

Miscarriages: _____