THE LAKEWOOD GROUP, LLC

Mental Health Services

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MEDICAL HISTORY REVIEW QUESTIONNAIRE

Please complete every question. Use additional pages if necessary. Thank you.

NAME _____ AGE _____ MARITAL STATUS _____

QUESTIONNAIRE COMPLETED BY _____ DATE _____

MEDICAL CARE: Are you or have you ever been under the care of a physician for any type of medical problem? If so, please explain. Please include dates.

CHECKUP: Approximate date of your last checkup:_____ Done for : (Circle) Illness Routine Work Insurance

Name of Doctor_____ Address_____

Included in checkup: (Circle) History Physical Blood Tests Urine Tests X-Ray EKG (cardiogram) Pap Smear

Date of your last tetanus shot:_____

MEDICATION: Please list all medications (prescription and non-prescription) that you currently take and dosages, if known.
□ none

ALLERGIES: Please list all medications you are allergic to including X-Ray dye.
□ none

HOSPITALIZATIONS AND SURGERY: List any and all surgeries (problem, year, location, hospital or doctor).
□ none

Head injuries, motor vehicle accidents, falls with injury, blackouts, loss of consciousness, fainting (date, treatment required, problems afterward).
□ none

List any psychiatric treatment you have had (problem, year, location, doctor)
□ none

List any psychological treatment or counseling you have had (problem, year, location, doctor or counselor)
□ none

WEIGHT: Now_____One year ago_____Have you had a 10 lb. Weight change within the last year?_____

ALCOHOL AND TOBACCO: Do you smoke?_____How much?_____How long?_____

Do you drink alcohol? (Circle) Never, Less than one drink daily, 1-2 daily, More than 2 daily

Have you ever drunk more heavily than you do now?_____Have you ever taken unprescribed drugs (including street drugs)?_____ If so, specify_____

		YES	NO	EXPLAIN ALL YES ANSWERS
1.	Have you had any fever in the last week?			
2.	Do you have frequent headaches? If so, describe what they are like			
3.	Have you had a recent change in your vision or hearing?			
4.	Have you ever had numbness, severe muscular weakness?			
5.	Have you ever had trouble with dizziness?			
6.	Have you had seizures or tics?			
7.	Have you had unusual sensitivity to heat or cold or insensitivity?			
8.	Do you have trouble breathing, a chronic cough, or have you coughed up blood?			
9.	Do you have chest pains, high blood pressure, or heart problems?			
10.	Do you have abdominal pains, change in bowel habits, or rectal bleeding?			
11.	Do you have difficulty or pain in urination, or blood in urine?			
12.	Have you had blackout spells?			
13.	Do you have trouble with walking or balance?			
14.	Do you have back pain or other back problems?			
15.	Do you have arthritis?			
16.	Have you had frequent ear infections?			
17.	Have you had frequent sore throats?			

FOR WOMEN: (If you are uncomfortable answering any of these questions, you may respond later in private with your physician.)

Are you having periods? Yes____No____Date of last normal menstrual period:_____

Menses: (Check appropriate blank) Normal____ Heavy____ Irregular____

Please explain_____

Possibility of current pregnancy. (Check one) Yes____ No____

Pregnancies: Number____ Miscarriages ____ Abortions ____ Complications_____

History of venereal disease (herpes, gonorrhea, syphilis) _____

Date of last pap smear _____ Birth Control Pills_____

Recent change in sexual functioning_____

FOR MEN: (If you are uncomfortable answering any of these questions, you may respond later in private with your physician.)

Age of puberty_____ History of venereal disease (herpes, gonorrhea, syphilis, non-specific discharge)_____

_____

Recent change in sexual functioning _____

ADOLESCENT AND CHILDREN---Inoculation dates:

DPT or TD_____ basic series_____ boosters_____

Polio_____ basic series_____boosters_____

Measles_____ Mumps_____

Rubella _____ Most recent Tine Test_____