Menninger

PATIENT HEALTH HISTORY

PATIENT INFORMATION *(Please Print Clearly)*

First Name: _____ Last Name: _____

Date of Birth: _____ ☐ Male ☐ Female If Minor, Who Has Custody: _____

Allergies to food, medicine, other: _____

Current Family Physician: _____ Contact Number: _____

Height: _____ Weight: _____ Date of Last Physical Exam: _____

Any problems experienced, by Mother, during pregnancy

Did patient experience problems/complications during birth? ☐ Yes ☐ No

If yes list problems (include any alcohol, cigarettes, drug use, complications, etc.)

_____

Does the patient have current or past problems in the following areas? (please check all that apply)

☐ Asthma
☐ Skin Problems
☐ Wounds not healing/Easy bruising
☐ Vision/ glasses needed
☐ Gums/ Teeth
☐ Hearing
☐ Headaches
☐ Head Injuries
☐ Blackouts/Fainting/Seizure
☐ Numbness/Tingling
☐ Thyroid
☐ Blood Sugar
☐ Sickle Cell
☐ HIV/AIDS
☐ Fatigue
☐ Anemia/Low Blood Count
☐ Breathing/ Shortness of Breath
☐ Fever
☐ Eating
☐ Alcohol
☐ Street Drugs
☐ High Blood Pressure
☐ Heart Disease/Chest Pain
☐ Rheumatic Fever
☐ Nausea/Vomiting
☐ Ulcers
☐ Liver/Yellow Jaundice
☐ Kidney/Bladder
☐ Difficulty Walking/Standing
☐ Joint Pain/Arthritis
☐ Sleeping too much
☐ Sleeping too little
☐ Lead/Chemical Exposure
☐ Frequent Accidents
☐ Pain now or in recent past
☐ Weight: Gain ____ Loss____
____Pounds in ____ Time
☐ Cancer: _____

Has the patient or family member had: (please check all that apply)

Cough for more than three weeks	☐ Patient	☐ Family Member
Coughed up blood in the last six months	☐ Patient	☐ Family Member
Fever and/or night sweats	☐ Patient	☐ Family Member
Exposure to anyone with tuberculosis	☐ Patient	☐ Family Member

Female Only

Age at first period: _____ Date of last period: _____ Has patient received first pelvic exam: ☐ Yes ☐ No

Prior Medical Hospitalization(s)

Has the patient ever been hospitalized for any medical reasons such as illness, accidents, surgeries or tests? ☐ Yes ☐ No
(If yes)

Date: _____ Reason: _____ Where: _____

Date: _____ Reason: _____ Where: _____

Date: _____ Reason: _____ Where: _____

NAME OF PATIENT: _____

Is the patient currently taking medication(s)? ☐ Yes ☐ No

If yes, (list all psychiatric and medical to include prescription, over the counter and herbals)

Name of Medication	Dose/Amount	How Often	Reason for Medication

Has the patient taken any psychiatric medications in the past? ☐ Yes ☐ No ***(If yes, complete below)***

Name of Medication	Dose/Amount	How Often	Reason for Medication

Has the patient had psychiatric care in the past? (such as psychiatrist, psychologist, social worker, nurse, counselor or psychological testing) ☐ Yes ☐ No ***(If yes, complete below)***

For What Reason	When	Where	Was Patient Hospitalized

Have any of the patient's family members had any of the following? ***(please check all that apply)***

☐ Depression
☐ Bipolar Disorder
☐ Suicide
☐ Schizophrenia
☐ Manic Depression
☐ Anxiety Disorder
☐ Alcohol/Drug Problems
☐ High Blood Pressure
☐ Thyroid
☐ Multiple Sclerosis
☐ Diabetes
☐ Stroke
☐ Dementia/Senility
☐ Stomach Problems
☐ Heart Problems
☐ Nerves
☐ Sickle Cell
☐ Attention Deficit Hyperactivity Disorder
☐ Cancer: _____
☐ Seizures (what kind) _____
☐ Other: _____

Please identify family member and disorder here:

_____

_____

NAME OF PATIENT: _____

Does the patient need assistance in any of the following areas? ***(please check all that apply)***

☐ Bathing ☐ Feeding ☐ Tying shoelaces ☐ Money Management
☐ Hygiene ☐ Toileting ☐ Dressing ☐ Driving
☐ Ability to walk independently

Describe assistance for each box checked above:

_____

_____

_____

Signature of person completing the form: _____ Date: _____

Relationship to the patient: _____

Clinician's Signature: _____ Date/Time _____