

**BEARDEN BEHAVIORAL HEALTH / TRINITY MEDICAL
ADULT HISTORY FORM**

NAME: _____ **DATE:** _____
DOB: _____ **SEX:** MALE FEMALE

SOCIAL HISTORY:

Please check one: Single Married Divorced Separated Widowed Significant Other

Employed? Yes No Disabled **Employer:** _____

Do you have children: Yes No **If so, how many?** _____ **Ages?** _____

Who resides in the home with you? _____

Your occupation: _____ **Highest level of education completed:** _____

Do you drink alcohol? Yes No **If yes, how often?** Seldom Occasionally Often

Illegal drug use? Never In the Past Currently **Do you exercise?** Yes No

Do you smoke cigarettes? Never In the Past (date you quit: _____) Yes, current smoker

Do you use other forms of tobacco? Snuff Pipe Cigar Chew

PERSONAL MEDICAL HISTORY:

Primary Care Physician: _____ **Phone Number:** _____

May we exchange information with your Primary Care Physician? Yes No

CURRENT MEDICATIONS (including Vitamins & OTC)	DOSE	x PER DAY	PRESCRIBING DOCTOR

ALLERGIES OR REACTIONS TO MEDICATIONS: YES NO, I AM NOT ALLERGIC TO ANY MEDICATIONS

If yes, please list the medication(s), as well as the reaction or side effect:

PERSONAL MEDICAL HISTORY, CONTINUED

PLEASE LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES YOU MAY HAVE: _____

PLEASE LIST ANY SURGERIES AND HOSPITALIZATIONS INCLUDING DATE AND REASON:

PLEASE CHECK ALL OF THE FOLLOWING CONDITIONS YOU ARE OR HAVE BEEN TREATED FOR:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Transfusion | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Drug Overdose |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Headaches(non-Migraine) |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Palpitations | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Kidney Disease/Stones | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Muscle Disease | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Obsessive-Compulsive Disorder |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Muscle Disease | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> STD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sinus Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Urinary Infections | <input type="checkbox"/> Tuberculosis/ + TB Skin Test |

OTHER _____

FEMALES: Age of first menses: _____ Date of Last Menstrual Period: _____
Do you suffer from PMS? _____ Date of Menopause: _____
of Pregnancies: _____ Any miscarriages, abortions or tubal pregnancies? _____

MALES: Prostate Problems: Yes No Testicular Problems: Yes No
Low Testosterone: Yes No Erectile Dysfunction: Yes No

