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 <u>ARE</u> OR <u>HAVE BEEN</u> TREATED FOR:

__Allergies	__Asthma	__Arthritis	__Anxiety
__Anemia	__Abnormal EKG	__Alcoholism	__Acid Reflux
__Blood Clots	__Bleeding Problems	__Transfusion	__Back Pain
__Breast Lumps	__Cancer	__Chest Pain	__Diabetes
__Depression	__Dizziness	__Drug abuse	__Drug Overdose
__Eczema/Psoriasis	__Emphysema/COPD	__Erectile Dysfunction	__Epilepsy/Seizures
__Glaucoma	__Gallbladder Disease	__Gout	__Headaches(non-Migraine)
__Hearing Problems	__Heart Attack	__Heart Murmur	__Heart Disease
__Arrhythmia	__Palpitations	__High Blood Pressure	__Hepatitis
__High Cholesterol	__HIV/AIDS	__Insomnia	__Lymphoma
__Kidney Disease/Stones	__Irritable Bowel	__Learning Disability	__Liver Disease
__Leukemia	__Lupus	__Meningitis	__Migraines
__Muscle Disease	__ADD/ADHD	__Panic Attacks	__Obsessive-Compulsive Disorder
__Pancreatitis	__Pneumonia	__Muscle Disease	__Suicide Attempt
__STD	__Stroke	__Sinus Disease	__Thyroid Disease
__Ulcers	__Prostate Problems	__Urinary Infections	__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

FAMILY HISTORY:

Were you adopted? __Yes __No

Please put a checkmark in all applicable boxes below pertaining to your family medical history:

ILLNESS	FATHER	MOTHER	SIBLING	CHILD	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNT/ UNCLE
Heart Disease									
High Cholesterol									
High Blood Pressure									
Diabetes									
Heart Attack									
Stroke									
Kidney Disease									
Liver Disease									
Bleeding or Clotting D/O									
Asthma									
Anemia									
Skin Cancer									
Other Cancer									
Thyroid Disease									
Seizures/ Epilepsy									
HIV/AIDS									
Depression/ Anxiety									
Drug / Alcohol Addiction									
Suicide Attempt									