

Medical History Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Allergies \_\_\_\_\_

How did you hear about the Infusion Center/Services? \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone \_\_\_\_\_

Mental Health Providers: \_\_\_\_\_ Phone \_\_\_\_\_

### ALLERGIES

Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____

### PAST MEDICAL HISTORY

**Do you have any of these conditions?** Check appropriate box and provide date of onset

= Past Condition     = Current Condition

#### NEUROLOGIC / MOOD

- Depression \_\_\_\_\_
- Anxiety \_\_\_\_\_
- PTSD \_\_\_\_\_
- Insomnia \_\_\_\_\_
- Schizophrenia \_\_\_\_\_
- Hallucinations \_\_\_\_\_
- ADD/ADHD \_\_\_\_\_
- Suicidal \_\_\_\_\_
- \_\_\_\_\_
- History of Mental Health Crises \_\_\_\_\_
- \_\_\_\_\_
- Seizures \_\_\_\_\_
- Stroke \_\_\_\_\_
- Neuromuscular Disease \_\_\_\_\_
- History of Psychiatric Admission \_\_\_\_\_
- \_\_\_\_\_
- Other \_\_\_\_\_

#### METABOLIC / ENDOCRINE

- Hypothyroid (underactive) \_\_\_\_\_
- Hyperthyroidism (overactive thyroid) \_\_\_\_\_
- Other \_\_\_\_\_

#### RESPIRATORY

- Shortness of Breath \_\_\_\_\_
- Asthma \_\_\_\_\_
- Obstructive Sleep Apnea \_\_\_\_\_
- Pulmonary Hypertension \_\_\_\_\_
- Other Lung Disorders \_\_\_\_\_

#### GU /GI

- Kidney Disease \_\_\_\_\_
- Liver Disease \_\_\_\_\_
- Other \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**CARDIOVASCULAR**

- High Blood Pressure  
Controlled / Uncontrolled \_\_\_\_\_
- Chest Pain \_\_\_\_\_
- Heart Murmur \_\_\_\_\_
- Heart Attack \_\_\_\_\_
- Valve Disease \_\_\_\_\_
- Heart Failure \_\_\_\_\_
- Abnormal Heart Rhythm \_\_\_\_\_
- Bleeding Disorder \_\_\_\_\_
- Other \_\_\_\_\_

**PAIN**

- Acute Pain \_\_\_\_\_
- Chronic Pain \_\_\_\_\_
- Fibromyalgia \_\_\_\_\_
- Other \_\_\_\_\_

**INFECTIOUS**

- HIV \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Other \_\_\_\_\_

**HEMATOLOGY / ONCOLOGY**

- Bleeding Disorder \_\_\_\_\_
- Cancer (explain) \_\_\_\_\_  
\_\_\_\_\_
- Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER**

- Substance Abuse (please circle)  
    Marijuana      Cocaine      Methamphetamine  
                          Heroin            Ketamine
- Other Recreational drugs \_\_\_\_\_
- Last Use \_\_\_\_\_
- History of assault \_\_\_\_\_
- History of violent behavior \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST SURGICAL HISTORY**  None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**CURRENT MEDICATIONS / SUPPLEMENTS**  None

NAME / DOSE	Reason For Use

**I am currently compliant with all medications prescribed by my mental health provider**

Yes     No    **If no, please explain:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_