David A. Donovan Ph.D.

CLINICAL PSYCHOLOGY

MEDICAL HISTORY

This is your medical history form. All information will be kept confidential. The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out.

General Information

Name _____

Address _____

Contact phone numbers _____

Email _____

Birth date _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other _____ *Phone* _____

Address _____ *City* _____

Marital Status

☐ Single ☐ Married / Partner ☐ Divorced ☐ Widowed

Sex

☐ Male ☐Female ☐_____

Education

☐ Grade School ☐ Jr. High School ☐ High School
☐ College (2-4 years) ☐ Graduate School ☐ Degree _____

Occupation

Position _____ *Employer* _____

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Present Medical History
Check those questions to which you answer yes (leave the others blank)

☐ Has a doctor ever said your blood pressure was too high?
☐ Do you ever have pain in your chest or heart?
☐ Are you often bothered by a thumping of the heart?
☐ Does your heart often race?
☐ Do you ever notice extra heartbeats or skipped beats?
☐ Are your ankles often badly swollen?
☐ Do cold hands or feet trouble you even in hot weather?
☐ Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
☐ Do you suffer from frequent cramps in your legs?
☐ Do you often have difficulty breathing?
☐ Do you get out of breath long before anyone else?
☐ Do you sometimes get out of breath when sitting still or sleeping?
☐ Has a doctor ever told you your cholesterol level was high?
Comments:

Do you now have or have you recently experienced...

☐ Chronic, recurrent or morning cough?
☐ Episode of coughing up blood?
☐ Increased anxiety or depression?
☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
☐ Migraine or recurrent headaches?
☐ Swollen or painful knees or ankles?
☐ Swollen, stiff or painful joints?
☐ Pain in your legs after walking short distances?
☐ Foot problems?
☐ Back problems?
☐ Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhea?
☐ Significant vision or hearing problems?
☐ Recent change in a wart or a mole?
☐ Glaucoma or increased pressure in the eyes?
☐ Exposure to loud noises for long periods?
☐ An infection such as pneumonia accompanied by a fever?

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☐ Significant unexplained weight loss?
☐ A fever, which can cause dehydration and rapid heart beat?
☐ A deep vein thrombosis (blood clot)?
☐ A hernia that is causing symptoms?
☐ Foot or ankle sores that won't heal?
☐ Persistent pain or problems walking after you have fallen?
☐ Eye conditions such as bleeding in the retina or detached retina?
☐ Cataract or lens transplant?
☐ Laser treatment or other eye surgery?
Comments:

Women only answer the following.
Do you have
☐ Menstrual period problems?
☐ Significant childbirth - related problems?
☐ Urine loss when you cough, sneeze or laugh?
Are you on any type of hormone replacement therapy? **YES** **NO**
Date of the last pelvic exam and / or Pap smear _____
Comments:

Men and women answer the following.
List any prescription medications you are now taking:

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:

Date of last complete physical examination _____
☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last dental check up _____
☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

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List any other medical or diagnostic test you have had in the past two years:

List hospitalizations, including dates of and reasons for hospitalization:

List any drug allergies:

Past Medical History
Check those questions to which your answer is yes (leave others blank)

☐ Heart attack if so, how many years ago? _____
☐ Rheumatic Fever
☐ Heart murmur
☐ Diseases of the arteries
☐ Varicose veins
☐ Arthritis of legs or arms
☐ Diabetes or abnormal blood-sugar tests
☐ Phlebitis (inflammation of a vein)
☐ Dizziness or fainting spells
☐ Epilepsy or seizures
☐ Stroke
☐ Diphtheria
☐ Scarlet Fever
☐ Infectious mononucleosis
☐ Nervous or emotional problems
☐ Anemia
☐ Thyroid problems
☐ Pneumonia
☐ Bronchitis
☐ Asthma
☐ Abnormal chest X-ray
☐ Other lung disease
☐ Injuries to back, arms, legs or joint
☐ Broken bones
☐ Jaundice or gall bladder problems

Comments:

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Family Medical History

Father
☐ Alive Current age _____

My father's general health is:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Reason for poor health _____

☐ Deceased ☐ Age at death _____

Cause of death _____

Mother
☐ Alive Current age _____

My mother's general health is:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Reason for poor health _____

☐ Deceased ☐ Age at death _____

Cause of death _____

Siblings
Number of brothers _____ Number of sisters _____

Age range _____

Health problems _____

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Familial Diseases
Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those to which the answer is yes (leave other blank)
☐ Heart attacks under age 50
☐ Strokes under age 50
☐ High blood pressure
☐ Elevated cholesterol
☐ Diabetes
☐ Asthma or hay fever
☐ Congenital heart disease (existing at birth but not hereditary)
☐ Heart operations
☐ Glaucoma
☐ Obesity (20 or more pounds overweight)
☐ Leukemia or cancer under age 60
☐ Other Health Risk Factors

Smoking
Have you ever smoked cigarettes, cigars or a pipe?
☐ Yes ☐ No
(If no, skip to diet section)
If you did or now smoke cigarettes, how many per day? _____ Age started _____
If you did or now smoke cigars, how many per day? _____ Age started _____
If you did or now smoke a pipe, how many pipefuls a day? _____ Age started _____
If you have stopped smoking, when was it? _____
If you now smoke, how long ago did you start? _____

Diet
What do you consider a good weight for yourself? _____
What is the most you have ever weighed (including when pregnant)? _____
How old were you? _____
My current weight is _____
One year ago my weight was _____

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Drugs and Alcohol Use
Do you ever drink alcoholic beverages?
☐ Yes ☐ No

If yes, what is your approximate intake of these beverages?
Beer ☐ None ☐ Occasional ☐ Often If often, _____ per week
Wine ☐ None ☐ Occasional ☐ Often If often, _____ per week
Hard Liquor ☐ None ☐ Occasional ☐ Often If often, _____ per week

At any time in the past, were you a heavy drinker
(consumption of six ounces of hard liquor per day or more)?
☐ Yes ☐ No

Do you ever use recreational drugs?
☐ Yes ☐ No ☐ In Recovery ☐ Decline to State

If yes, what is your approximate intake of these substances?
☐ None ☐ Occasional ☐ Often If often, _____ per week

Comments:

Safety
Do you use seatbelts consistently? **YES** **NO**

Do you use a bike helmet regularly? **YES** **NO**

Is violence at home a concern for you? **YES** **NO**

Do you feel safe in your current relationship? **YES** **NO**

Do you have a gun in your home? **YES** **NO**

Other concerns?

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