

Insight Medical Group LLC

Health History Form

Name: _____

Date of Birth: ____/____/____

Reason for today's visit: _____

CURRENT MEDICATIONS

Name of Medication	Strength (ex. 500 mg)	Dosing Instructions (ex. Twice a day)

ALLERGY HISTORY Height _____ Weight _____ BP _____ Pulse _____

No Known Allergies Medication Allergies Environmental/Seasonal Allergies Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication)	Reaction (ex. Rash, nausea, respiratory, shock, etc.)

SOCIAL HISTORY *(Please circle all applicable responses)*

Marital Status	Single	Significant Other	Married	Divorced	Widowed
Sexual Orientation	Heterosexual	Gay	Lesbian	Bisexual	Transgender non binary
Living Situation	Alone	Spouse/Significant other		Children/Family	
	Homeless	Residential		Other:	
Females- Are you pregnant?	Yes / No	Hysterectomy	Menopause	Tubal ligation	
What are your hobbies?					
Education (highest level)	9	10	11	12	Some college Associates Bachelors
	GED			Masters	PhD
Employment?	Full-time	Part-time	Unemployed	Seeking employment	Disabled Retired
If yes, Employer:	Occupation:				# of Years:
Previous work experience?	Yes / No	If yes, description:			
Military History	None / Past / Current		Army	Navy	Marines Coast Guard National Guard
Combat?	Yes / No	If yes, Where:			
Discharge?	Yes / No	If yes:	Honorable	General	Dishonorable Retired Other
VA Disability?	Yes / No	If yes, due to:			
Spiritual/ Religious Affiliation?	Yes / No	Practicing/ Role of Faith Past & Present?			
Receiving Benefits?	Yes / No	APTD	SSI	SSDI	Food Stamps Fuel Asst. Section 8 Disability
		Public/HUD Housing	PASS Plan	Workers comp	Unemployment

If applicable, amount?

Tobacco Use?	Yes / No	Cigarettes / Cigars / Chew	Per day:
<i>If no, have you ever?</i>	Yes / No	Cigarettes / Cigars / Chew	Per day:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea / Soda / Energy Drink	Per day:
Do you exercise?	Yes / No	Type?	
Do you wear your seatbelt?	Yes / No	If yes, percent of time	

MEDICAL HISTORY (Please check any of the following that you have or have had in the past)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dementia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Glaucoma/Cataracts | <input type="checkbox"/> Immune Disorders | |

- Are you/do you have: Obsessive compulsive? _____ Eating disorder? _____ Panic Attacks? _____
- Have you participated in high-risk sexual practices? _____ If so, please describe: _____
- Have you had Hepatitis? Yes No Venereal Disease? Yes No Last HIV test _____
Results? _____
- Do you now have, or have you ever had, seizures or convulsions? Yes No
If yes, when, and what condition caused them? _____ When was the last seizure or convulsion? _____

For Women Only:

At what age did you start to menstruate? _____

Do you now have, or have you had, any problems with your menstrual period? Yes No

If yes, please describe these problems: _____

Have you had any:

Pregnancies? Yes No If yes, how many? _____ When? _____ Were you using? _____

Miscarriages? Yes No If yes, how many? _____ When? _____ Were you using? _____

Abortions? Yes No If yes, how many? _____ When? _____ Were you using? _____

Menopausal symptoms or treatment? If yes, when? _____

For Men Only:

Do you now have, or have you had, problems with your prostate, difficult or painful urination, or impotence?

Yes No If yes, please describe those problems: _____

FAMILY HISTORY (Please tell us about your immediate family)

CHILDREN None

First Name	Last Name	Age	Living With?	Custody?	Quality of Relationship
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	

SPOUSE/SIGNIFICANT OTHER None

Name	Age	Occupation	Quality of Relationship

Relationship	Age	Marital Status	Occupation	Living with?	Quality of Relationship
Mother				Yes / No	
Father				Yes / No	
Sibling:				Yes / No	
Sibling:				Yes / No	
Sibling:				Yes / No	
Other:				Yes / No	
Place of Birth:			Place of upbringing:		
Family is:	Intact	Parents Separated/Divorced		Parents Remarried	
Resided with:	Mother	Father	Adopted	Orphaned	Other:

<i>Health History</i>	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/ Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy					
Asthma					
Blood Disease					
Other:					

Contact with Family (check all that apply)

- Visit at least monthly
 Involved with treatment providers
 Family is available locally
 Supportive
 Knowledgeable about mental illness
 Family members not available
 Non-supportive
 Involved in NAMI or other support group
 Satisfied with family/relationship contact
 Not satisfied with family relationship/contact

SUBSTANCE ABUSE HISTORY

Family Substance Abuse (Please check any family that apply, and list substance abused)

- None
 Parents: _____
 Siblings: _____
 Extended Family: _____

Do you or your family think you have a problem with:

- Shopping? Yes No
Barbiturates? Yes No
Internet? Yes No
Sex Addiction? Yes No
Gambling? Yes No

Have you had any previous rehab or **treatment of substance abuse?** Yes No

Where?	Reason there?	How Long?	In patient/ Outpatient?	Date

(Please indicate which of the following drugs you have used, if any)

Substance	Age at first use	How often you use	How much you use	Method (s) you use	How long since last use
Alcohol					
Methamphetamine					
Amphetamine					
Barbiturates					
Cocaine (powder)					
Cocaine (crack)					
Hallucinogens					
Heroin					
Methadone					
Morphine					
Opium					
Inhalants					
Marijuana/Hashish					
PCP (Angel Dust)					
Ketamine (Special K)					
Ecstasy (x)					
Other: _____					

Did/do you go to "meetings?" _____ Do you have a sponsor? _____

Do you see a psychiatrist and if so who and how long? _____

Do you see a therapist or counselor and if so who and how long? _____

Have you ever been treated for depression if so when? _____

LEGAL HISTORY (Please report any and all legal issues)

Legal or Criminal Involvement?	Yes / No	<i>Court order</i>	<i>Probation</i>	<i>Parole</i>	<i>Restraining Order</i>		
<i>Found not competent to stand trial</i>		<i>Homicide or attempted homicide</i>		<i>Sexual Assault</i>	<i>Arson</i>	<i>Assault</i>	<i>Felony</i>
Probation/Parole Officer	Current / Past	Name:		County:			
DUI (date):	Warrants (date):			Violent Crime (date):			
Incarceration, date(s):		How long:		Reason:			
Do you have firearms at home?	Yes / No	<i>If yes, Are they locked?</i>		Yes / No			

MENTAL HEALTH

Stressful events over the last year:

- | | | |
|---|--|--|
| <input type="checkbox"/> Recent Hospital Discharge | <input type="checkbox"/> Access to Healthcare | <input type="checkbox"/> Financial Problems |
| <input type="checkbox"/> Death/ Divorce/ Separation | <input type="checkbox"/> Witness/Victim of Violence | <input type="checkbox"/> Legal Problems |
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> History/Current Abuse | <input type="checkbox"/> Social/Environmental Problems |
| <input type="checkbox"/> Move | <input type="checkbox"/> Disability (self or family) | <input type="checkbox"/> Other Family Problems |
| <input type="checkbox"/> Educational Problems | <input type="checkbox"/> Parenting Issues | <input type="checkbox"/> Health Problem: _____ |
| <input type="checkbox"/> Housing Problems | <input type="checkbox"/> Job Loss | <input type="checkbox"/> Other: _____ |

Please check symptoms experienced in the last 4 weeks:

MOOD <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Hopelessness	<input type="checkbox"/> Mood Changes <input type="checkbox"/> Sadness <input type="checkbox"/> Elation (happier than normal) <input type="checkbox"/> Anger/Rage	<input type="checkbox"/> Overwhelming guilt/shame <input type="checkbox"/> Difficulty enjoying life <input type="checkbox"/> Irritability
BEHAVIORS <input type="checkbox"/> Hurting yourself <input type="checkbox"/> Doing the same thing repeatedly	<input type="checkbox"/> Uncontrolled spending/gambling <input type="checkbox"/> Increased alcohol/drug use	<input type="checkbox"/> Reckless behavior <input type="checkbox"/> Social Isolation
PHYSICAL <input type="checkbox"/> Increased Sleep <input type="checkbox"/> Decreased Sleep <input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Panic/ Anxiety Attacks <input type="checkbox"/> Increased Appetite/ weight gain <input type="checkbox"/> Decreased Appetite/ weight loss <input type="checkbox"/> Disturbing nightmares/dreams	<input type="checkbox"/> Agitation/Restless <input type="checkbox"/> Unusual sensory experience (smell, taste) <input type="checkbox"/> Other (specify):
THINKING <input type="checkbox"/> Wanting to take your life <input type="checkbox"/> Wanting to hurt someone else <input type="checkbox"/> Seeing/Hearing things that aren't there <input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Intrusive negative thoughts <input type="checkbox"/> Flashbacks <input type="checkbox"/> Irrational fear <input type="checkbox"/> Racing thoughts <input type="checkbox"/> Paranoia	<input type="checkbox"/> Low self-esteem <input type="checkbox"/> Academic/work problems <input type="checkbox"/> Easily distracted <input type="checkbox"/> Thinking same thought repeatedly <input type="checkbox"/> Memory problems
INTERPERSONAL <input type="checkbox"/> Increased conflict w/ others <input type="checkbox"/> Increased family conflict <input type="checkbox"/> Difficulty making/keeping friends	<input type="checkbox"/> Socially withdrawn/isolation <input type="checkbox"/> Increased sexual problems/concerns <input type="checkbox"/> Increased social anxiety <input type="checkbox"/> Problems with intimacy	<input type="checkbox"/> Increased difficulty tolerating others <input type="checkbox"/> Trouble with law/authority figures <input type="checkbox"/> Intermittent relationships

TREATMENT QUESTIONNAIRE

Have you had any previous **psychiatric hospitalizations**? Yes No

Where	When	Reason

Have you had any previous **outpatient mental health treatment**? Yes No

Where	When	Reason

Have you had any previous **prescribed psychiatric medications**? Yes No

Medication	Prescribing Doctor	Dates

Have any family members had a history of **mental illness**? Yes No

Persons	Diagnosis or Symptoms	Treatments

Have you ever experienced any **trauma**? Yes No

If yes, have you been: Neglected Physically Abused Sexually Abused Don't Know

Any other incidents of **trauma**: Emotionally Abused Witness/Victim of violence Acts of War Fire Serious Accidents Other

Describe:

How are you **sleeping**? (Describe any recent changes or problems)

How is your **appetite**? (Include any recent weight changes)

What **leisure or stress reduction activities** do you use?

Past **interests/activities**:

Do symptoms interfere with your ability to work or get things done? Yes No

Additional Comments/Information:

The above information is thorough and accurate to the best of my knowledge.

Patient Signature (or Guardian)

Date