MEDICAL HISTORY

Name:_____ Date_____

1. **Major Medical Problems** (please check appropriate boxes)
   - ☐ Heart Problems ☐ Diabetes
   - ☐ High Blood Pressure ☐ Bladder Problems
   - ☐ Other Major Illnesses_____

   Ever been hospitalized for any medical conditions? ☐ YES ☐ NO
   If yes, please explain:

   _____

   _____

   Ever had surgery? ☐ YES ☐ NO If yes, please list dates and procedures:

   _____

   _____

   Ever taken medications for a medical problem? ☐ YES ☐ NO
   If so, what medications?

   _____

   Ever had a convulsion (seizure)? ☐ YES ☐ NO

   Ever had a head injury? ☐ YES ☐ NO
   If yes, did it result in a loss of consciousness? ☐ YES ☐ NO

   Ever had glaucoma? ☐ YES ☐ NO

   Any allergies to medications? ☐ YES ☐ NO If yes, what medications?

   _____

2. **Past Psychiatric Medications**:
   Please list psychiatric medications that you have previously used and why you discontinued them.

   _____

   _____

   _____

3. **Current Medications** (Medical and Psychiatric):

Medication	Dose	How Long Have You Taken It?	Has It Helped?	Any Side Effects?
1.				
2.				
3.				
4.				
5.				