

Medical History

Instructions

To determine the cause of depression, the doctor needs details about your history, including current and past medical problems, medications, health habits, and family history. The information may be gathered from both the person and family members.

My name is: _____

My telephone is: _____

Past Medical History

Have you been affected by any of the following problems or conditions? If so, when was it first found?

Condition	When?	Yes	No
Heart disease, angina	_____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid trouble	_____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	_____	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	_____	<input type="checkbox"/>	<input type="checkbox"/>
Drinking problem	_____	<input type="checkbox"/>	<input type="checkbox"/>
Suicide attempt	_____	<input type="checkbox"/>	<input type="checkbox"/>
Street drug use	_____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Vision or hearing loss	_____	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	_____	<input type="checkbox"/>	<input type="checkbox"/>
Bad nerves or anxiety	_____	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric problem	_____	<input type="checkbox"/>	<input type="checkbox"/>
Spells of extremely high energy	_____	<input type="checkbox"/>	<input type="checkbox"/>

Current Medical History

Please list the medical conditions currently affecting you or that you are currently receiving treatment for.

When did it begin?	Condition
_____	_____
_____	_____
_____	_____
_____	_____

Psychiatric History

Please list all mental health or psychiatric conditions or treatments you have had, with the approximate date of onset for each.

Date	Condition or Treatment
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Education and Employment

How far did you go in school? _____

What type of work did you do? _____

Have you ever had electroconvulsive (ECT) or “shock” therapy? _____ No _____ Yes

Family History

Please indicate which family members have had any of the following medical conditions (give the relationship to you, not the relative's name).

Condition	Family Member(s)
Alzheimer's disease or dementia	_____
Parkinson's disease	_____
Depression	_____
Stroke	_____
Heart Disease	_____
Cancer	_____
Diabetes	_____
Mental Illness	_____
Suicide	_____

Health Habits

If you ever smoked, how many packs per day and for how many years? _____

If you no longer smokes, when did you quit?

Do you drink alcoholic beverages on most days?

_____ No _____ Yes

If yes, how many drinks per day, usually?

(1 drink is 1 beer, 6 oz of wine, or 2 oz of hard liquor)

If yes to drinking, please circle the best answer to each question below.

Have you ever felt you ought to cut down on your drinking *Yes No*

Have people annoyed you by criticizing your drinking? *Yes No*

Have you ever felt bad or guilty about your drinking? *Yes No*

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? *Yes No*

**Medication
History**

Please list all **prescription** medicines that you are currently taking

Name of Medication	Strength and Times per Day
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all **over-the-counter** medicines that you are currently taking at least once a week.

Name of Medication	Strength and Times per Day
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Review of
Systems**

Have you been bothered by any of the following problems in the past few months?

Please describe any problems briefly, with approximate dates. If you need more room, write on the back of the sheet. Leave the line empty if the problem had not occurred.

Problem	Description, dates(s)
Extreme nervousness	_____
Headaches	_____
Pain	_____
Problems having sex	_____
Extreme tiredness	_____
Serious health problem	_____
Problems sleeping	_____
Loss or gain of weight	_____
Problems with memory	_____
Digestive problems	_____
Constipation	_____
Loss of a loved one	_____
Difficult move	_____
Victim of violence or abuse	_____
Loss of or change in job	_____
Loss of a pet	_____