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 WEB www.rccmc.org

Brief Medical History

Name: _____ Age: _____ Date of Birth: _____

Primary Care Physician: _____

Physician Address: _____ Phone Number: _____

Permission to Contact: YES NO

(Most insurance companies require we ask permission to coordinate with your doctor, usually by letter. If you mark yes, then please sign release of information. If no, for any reason, no further documentation required.)

Hospital of Choice in case of Emergency: _____

Last Medical Exam: _____

List any medical problems you are currently experiencing: _____

Are you in any pain: YES NO Please rate the pain from 1-10 (1 being the least and 10 the greatest) .

What medications have you used past and present (especially medication used to address mental health issues)

Medication	Prescribing Doctor	Date Started	Date Ended
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you using any over the counter medications presently? If so, what? _____

Are you allergic to any medications? _____

Are you pregnant or do you have symptoms indicative of pregnancy? YES NO

Have you ever seen a Psychiatrist before: YES NO

If yes, when and please explain the outcome of these visits: _____

Please check any of the following problems that you experience:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aches and pains | <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Appetite disturbance |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Cancer : _____ | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Excessive drinking |
| <input type="checkbox"/> Feelings of unreality | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis A, B or C: _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Irritable bowel |
| <input type="checkbox"/> Syndrome | <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Menopause | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Overeating |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Phobias: _____ | <input type="checkbox"/> Poor impulse control |
| <input type="checkbox"/> Premenstrual Syndrome | <input type="checkbox"/> Seizures (including epilepsy) | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Tremors | <input type="checkbox"/> Ulcers |

Psychiatrist Signature _____

Date _____

Comments/Recommendations: _____