Harvest Counseling

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MEDICAL HISTORY

TODAY′S DATE:_____ BIRTH DATE: _____

NAME:_____PRIMARY CARE PHYSICIAN:_____
(PRINT)

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE, OR HAVE HAD:

	YES	NO		YES	NO
ANEMIA/BLOOD DISEASE	____	____	ASTHMA/EMPHYSEMA	____	____
LOSS OF CONSCIOUSNESS	____	____	SEIZURES/EPILEPSY	____	____
HEPATITIS/LIVER DISEASE	____	____	FREQUENT HEADACHES/MIGRAINES	____	____
NECK/BACK PROBLEMS	____	____	KIDNEY DISEASE/STONES	____	____
CANCER/TUMOR/LEUKEMIA	____	____	THYROID PROBLEMS	____	____
ARTHRITIS/RHEUMATISM	____	____	JOINT PROBLEMS	____	____
HEART DISEASE/MURMUR	____	____	STROKE/PARALYSIS	____	____
HIGH BLOOD PRESSURE	____	____	STOMACH ULCERS	____	____
HERNIAS	____	____	DIGESTIVE/BOWEL PROBLEMS	____	____
IMMUNE DEFICIENCY	____	____	URINARY TRACT INFECTION	____	____
EYE PROBLEMS	____	____	TB/POSITIVE SKIN TEST	____	____
DEAFNESS/HEARING LOSS/RINGING	____	____	DIABETES	____	____
MULTIPLE SCLEROSIS	____	____	MENSTRUAL IRREGULARITIES	____	____

ANY OTHER CONDITIONS NOT LISTED ABOVE/COMMENTS ON ABOVE:

_____
_____
_____

CURRENT MEDICATION

NAME OF MEDICATION	**DOSAGE**	**FREQUENCY**

DO YOU HAVE ANY ALLERGIES, DRUG SENSITIVITIES OR PHYSICAL HANDICAPS?
EXPLAIN:_____

_____
_____

PLEASE LIST ANY ACCIDENTS OR OPERATIONS, ESPECIALLY THOSE REQUIRING HOSPITALIZATION:

_____ AGE:_____
_____ AGE:_____
_____ AGE:_____
_____ AGE:_____

MEDICAL HISTORY CONTINUED

FAMILY HISTORY

	CURRENT AGE	IF DECEASED, CAUSE OF DEATH	ILLNESSES	GENERAL HEALTH
FATHER				
MOTHER				
STEPFATHER				
STEPMOTHER				

SIBLINGS:

NAME	AGE	MARITAL STATUS	LOCATION

DO YOU SMOKE? YES____ NO____ CIGARETTES___ CIGARS___ PIPES___ HOW MUCH?_____ NUMBER OF YRS?___

DO YOU DRINK ALCOHOL? YES____ NO____WHAT KIND?___BEER _____WINE _____HARD LIQUOR
HOW OFTEN?_____

FOR FEMALES: ARE YOU PREGNANT? YES____ NO____
HOW MANY PREGNANCIES HAVE YOU HAD?_____ TERM _____ MISCARRIED _____
ABORTED_____ STILLBORN _____
DATE OF LAST MENSTRUAL CYCLE? _____

ILLICIT DRUG USE HISTORY

NAME OF DRUG	DATES USED	CURRENTLY ABSTINENT (Y/N)?

HAVE YOU RECEIVED ANY DRUG TREATMENT IN THE PAST? YES____ NO____

HAVE YOU EVER HAD ANY LEGAL ISSUES DUE TO THE USE OF ALCOHOL OR DRUG INTAKE? YES____ NO____ IF SO, EXPLAIN (INCLUDING WHAT/WHERE/WHEN/OUTCOME):

IS THERE ANY OTHER MEDICAL INFORMATION THAT MAY BE HELPFUL TO KNOW?

SIGNATURE OF PERSON COMPLETING MEDICAL HISTORY _____

CLIENT SIGNATURE:_____DATE:_____