PLEASE PRINT CLEARLY **Chart No.** ___________

Comprehensive Psychiatric Services, P.C.

MEDICAL INFORMATION FORM

Patient Name: ______________________________ Age: ______ Date: ____________

Physical Assessment

Height: ____ ft _____ inches Internist/Family Physician Name _________________________ MD or DO

Weight: _________ pounds Doctor Phone (______) _____________ City, State: ___________________

Date of last physical exam: ___/___/_____ Drug Allergies: _________________________________

Date of last hospitalization: ___/___/_____ >> Hospital: _________________________

Your perception of your current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Smoking cigarettes? ______ pack(s) per day

Coffee/tea? _____ cups per day Caffeinated soda or energy drinks? _____ bottles per day

Have there been changes in your sleep pattern? ☐ Yes ☐ No _____ Average hours of sleep per night

Specify: ☐ interruptions ☐ difficulty falling asleep ☐ early awakening ☐ other ______________________

Have there been changes in your eating habits? ☐ Yes ☐ No _____ Number of meals per day

Have there been changes in your weight? ☐ Yes ☐ No _____ Pounds gained ____ Pounds lost

Alcohol Consumption

Describe type and quantity of alcohol use in last 48 hours: _________________________________

Indicate average daily or weekly usage over the past six months:

Beer _____ drinks per day/week Wine _____ drinks per day/week Liquor _____ drinks per day/week

At what age did you first use alcohol? ______ At what age did it first cause problems? _____

Have you abstained from alcohol use in the past six months? ☐ Yes ☐ No How long? _______________

Drug History

Describe type and quantity of illicit drug use in last 48 hours: _______________________________

Please list below all of the drugs, including marijuana, that you have **ever** used below (**do not include medication taken as prescribed**)

Name of Drug	How much	How often	How Used	Age at first use	Still use?

Date: _______________ Reviewed by: ___________________________________

PLEASE COMPLETE BOTH SIDES OF THIS FORM

PLEASE PRINT CLEARLY

Comprehensive Psychiatric Services, P.C.

MEDICAL INFORMATION FORM

Patient and Family Medical Information

Have you or any member of your family treated for:

Condition	Who?	When?	How Long?	Physician	Treatment
Alcohol Abuse					
Anxiety or panic disorder					
Asthma or other lung disease					
Attention deficit disorder					
Blackouts/dizzy spells					
Colitis, digestive or gastrointestinal					
Diabetes, high or low blood sugar					
Drug abuse					
Psychosis (hallucinations, delusions or paranoia)					
Heart disease or cardiovascular					
High or low blood pressure					
Liver disease, jaundice					
Kidney disease					
Mood disorder (depression or bipolar disorder)					
Migraine or chronic headaches					
Seizures or epilepsy					
Suicide attempts or act					
Thyroid					

Current Medical Problems:

Description Duration Recurrence Treating Physician

Medications Prescribed:

Name Dose Frequency How long?

PLEASE COMPLETE BOTH SIDES OF THIS FORM