

ALLIANCE BEHAVIORAL MEDICINE, LLC  
MEDICAL HISTORY

PLEASE PRINT  
NAME

DATE \_\_\_\_\_

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

EDUCATION (YRS COMPLETED) \_\_\_\_\_ RELIGIOUS PREFERENCE \_\_\_\_\_

ILLNESSES SUCH AS: DIABETES, HYPERTENSION, SEIZURES, THYROID, LUNG OR HEART DISEASE: \_\_\_\_\_

HISTORY OF PHYSICAL INJURIES OR HEAD INJURIES: \_\_\_\_\_

LIST CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER, NUTRITIONAL SUPPLEMENTS, VITAMINS):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRIMARY DOCTOR OR CLINIC: \_\_\_\_\_ PREFERRED PHARMACY \_\_\_\_\_

ALLERGIES OR ANY DRUG REACTION: \_\_\_\_\_

ARE YOUR VACCINATIONS UP-TO-DATE? YES \_\_\_\_\_ NO \_\_\_\_\_

<b>SMOKING</b>
PACKS PER DAY _____
# OF YEARS _____
YEAR STOPPED _____
PIPE__ CIGAR__ CHEW__
IF STILL SMOKING, WOULD YOU LIKE HELP STOPPING? _____

<b>ALCOHOL</b>
NEVER _____ OCCASIONAL _____
MODERATE _____ HEAVY _____
ALCOHOL PROBLEM: Yes _____ N _____

<b>DRUGS</b> (e.g. marijuana, cocaine, etc.):
_____
_____
_____

<b>CAFFEINE</b> (Coffee, Tea, Soda, Energy Drinks, etc.)
NEVER _____ OCCASIONAL _____
MODERATE _____ HEAVY _____

PRESENT WEIGHT: _____
WEIGHT CHANGE LAST YEAR: GAINED _____ LBS / LOST _____ LBS
HEIGHT: _____

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH (PAST/PRESENT ALCOHOL OR DRUG PROBLEM)
FATHER			
MOTHER			
BROTHERS: NUMBER:			
SISTERS: NUMBER:			
CHILDREN: NUMBER:			

<p><b>CHECK IF ANY RELATIVES HAVE HAD:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> DIABETES</li> <li><input type="checkbox"/> HEART TROUBLE</li> <li><input type="checkbox"/> HEART ATTACK</li> <li><input type="checkbox"/> HIGH BLOOD PRESSURE</li> <li><input type="checkbox"/> STROKE</li> <li><input type="checkbox"/> CANCER</li> <li><input type="checkbox"/> TUBERCULOSIS</li> <li><input type="checkbox"/> ULCERS</li> <li><input type="checkbox"/> ARTHRITIS</li> <li><input type="checkbox"/> OBESITY (OVERWEIGHT)</li> <li><input type="checkbox"/> SUICIDE</li> <li><input type="checkbox"/> MENTAL ILLNESS</li> <li><input type="checkbox"/> DEPRESSION</li> <li><input type="checkbox"/> MANIC DEPRESSIVE (BIPOLAR DISORDER)</li> <li><input type="checkbox"/> SCHIZOPHRENIA</li> <li><input type="checkbox"/> THYROID TROUBLE</li> <li><input type="checkbox"/> ALCOHOLISM OR DRUG ABUSE</li> </ul>
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