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	_____	☐	☐
Thyroid trouble	_____	☐	☐
Stroke	_____	☐	☐
Parkinson's disease	_____	☐	☐
Drinking problem	_____	☐	☐
Suicide attempt	_____	☐	☐
Street drug use	_____	☐	☐
Cancer	_____	☐	☐
Vision or hearing loss	_____	☐	☐
Chronic pain	_____	☐	☐
Dementia	_____	☐	☐
Bad nerves or anxiety	_____	☐	☐
Psychiatric problem	_____	☐	☐
Spells of extremely high energy	_____	☐	☐

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	