RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH

ADULT MEDICAL HISTORY SUMMARY

Part I – TO BE COMPLETED BY PATIENT OR PATIENT INFORMANT (Please Print)

Patient's Name: _____
(First) (Middle) (Last) (Maiden)

Name of Informant if other than Patient/Relationship: _____

Current Physician: _____
(Name) (Address/City)

Date of Last Physical: _____ **Do you have allergies?** ☐ **Yes** ☐ **No**

PLEASE CHECK ALL OF THE FOLLOWING WHICH YOU HAVE HAD IN THE PAST:

☐ Heart Problems	☐ Drug Use	☐ Liver Problems
☐ Shortness of Breath	☐ Cancer/Immune Disease	☐ Hepatitis/Jaundice
☐ Pain/Pressure in Chest	☐ Frequent/Severe Headache	☐ Diabetes
☐ High Blood Pressure	☐ Head Injury	☐ Tuberculosis (TB)
☐ Stomach Problems	☐ Stroke	☐ Sexually Transmitted Disease
☐ Alcohol Use	☐ Epilepsy/Convulsions	☐ Asthma/Hay Fever/Hives/Rash
☐ Dizziness/Fainting	☐ Kidney Problems	☐ Bedwetting/Soiling
☐ Seizures	☐ Thyroid Problems	☐ Unusual Bleeding
☐ PMS/Hormone	☐ Therapy	☐ Pregnancy

OTHER SERIOUS ILLNESS AND/OR MEDICAL TESTS: _____

SUBSTANCES YOU ARE ALLERGIC TO: _____

DESCRIPTION OF ALLERGIC RESPONSE/NATURE OF REACTION: _____

WITHIN THE PAST YEAR HAVE YOU TAKEN PRESCRIBED OR OTHER MEDICATIONS FOR:

Sleep Disturbance? Name: _____ Currently Using? ☐ Yes ☐ No

Nutrition/Weight Problem? Name: _____ Currently Using? ☐ Yes ☐ No

Nerves/Anxiety/Depression? Name: _____ Currently Using? ☐ Yes ☐ No

Pain? Name Name: _____ Currently Using? ☐ Yes ☐ No

Recreation/Relaxation? Name: _____ Currently Using? ☐ Yes ☐ No

Are you taking, or have you taken Antabuse? ☐ Yes ☐ No

Consumer Signature: _____ **Date:** _____

Consumer Name:_____

Part II – HISTORY TAKING FOR STAFF USE ONLY (Use Additional Sheets if Necessary)

1. SIGNIFICANT PAST ILLNESS, ACCIDENTS, HOSPITILIZATION, and MEDICAL PROBLEMS: _____

2. SIGNIFICANT FAMILY HEALTH HISTORY AND PROBLEMS: _____

3. SIGNIFICANT CURRENT MEDICAL PROBLEMS: _____

4. CURRENT PSYCHOTROPIC MEDICATION:

Name	Strength /Dose	Duration of Use

5. PAST PSYCHOTROPIC MEDICATION:

Name	Strength /Dose	Duration of Use	Adverse Reactions? (Yes/No)
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

6. OTHER CURRENT MEDICATIONS (Includes Prescription and Non-Prescriptive Drugs):

Name	Strength /Dose	Indication

7. CURRENT USE OF ALCOHOL AND/OR STREET DRUGS:

Name	Frequency/Amount

8. PAST USE OF ALCOHOL AND/OR STREET DRUGS:

Name	Frequency/Amount

IF ENTRIES ARE MADE TO EITHER QUESTION 7 OR QUESTION 8, PLEASE COMPLETE DRUG/ALCOHOL ASSESSMENT.

COMMENTS: _

_____ _

_____ _

_____ _____

Clinician Signature Date

_____ _____

Reviewing Physician Signature Date

_____

Reviewing Physician Printed Name