WellStep Atlanta LLC
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Patient Intake: Medical History

(To be completed by patient)

Use the opposite side of the page as necessary to complete your answers. Please print legibly.

Name ____

Address ____

Phone (w) ____________ (h) ____________ (c) ____________

DOB ______________ Age __________SS# ______________

Emergency Contact ____

Relationship to patient ______________ Phone ______________

Primary care physician ______________ Phone ______________

Date of last physical __________ Have you ever had an EKG? ( ) N Date __________

Current or past medical conditions (check all that apply)

( ) Asthma/respiratory
( ) Cardiovascular (heart attack, high cholesterol, angina)
( ) Hypertension
( ) Epilepsy or seizure disorder
( ) GI disease
( ) Head trauma
( ) HIV/AIDS
( ) Diabetes
( ) Liver problems
( ) Pancreatic problems
( ) Thyroid disease
( ) STDs
( ) Abnormal Pap smear
( ) Nutritional deficiency

Other (Please describe)

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If there a family history of any of the illnesses listed above, please put an "F" next to that illness

MD NOTES

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Is there a family history of anything NOT listed here? (Please explain)

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MD NOTES

Have you ever had surgery or been hospitalized? (Please describe)

MD NOTES

Childhood Illnesses

Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

Have you or a family member ever been diagnosed with a psychiatric or mental illness? (Please describe)

Have you ever taken or been prescribed antidepressants? ( ) N For what reason

Medication(s) and dates of use ______________________ Why stopped

Please list all current prescription medications and how often you take them (example: Dilantin 3x/day). DO NOT include medications you may be currently misusing (that information is needed later) ______________________

Please list all current herbal medicines, vitamin supplements, etc. and how often you take them

MD NOTES

Please list any allergies you have (penicillin, bees, peanuts)

MD NOTES

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Tobacco History

Cigarettes: Now ( ) N ( ) Y In the past? ( ) N ( ) Y

How many per day on average? _______ For how many years? _______

Pipe: Now ( ) N ( ) Y In the past? ( ) N ( ) Y

How many per day on average? _______ For how many years? _______

Have you ever been treated for substance misuse? ( ) N (Please describe when, where and for how long)

____

____

____

How long have you been using substances? _________

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							

Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? (   ) N (Please list)

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What was your longest period of abstinence?

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MD NOTES

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