Patient Health History **Gaertner Psychiatric, PC**

Name: ________________________ Date of birth: _______________ Age: _________

SS#: ____________________ Today's Date: _______________ Sex: ____ Height: ______

Marital Status: S M W D Separated Weight: ______

Primary Care Physician: _____________________________ Phone number: _____________

Other Physician: ________________________________ Phone number: _____________

Pharmacy Name: ________________________________ Pharmacy phone: ______________

PAST MEDICAL HISTORY: *Please check all the boxes that apply*

Problem	Date of onset	Problem	Date of onset
ADD/ADHD	☐ ________	Fibromyalgia	☐ ________
AIDS/HIV	☐ ________	GERD/Reflux	☐ ________
Amnesia	☐ ________	GI problems	☐ ________
Anxiety	☐ ________	Headaches	☐ ________
Auditory or visual Hallucination(s)	☐ ________	Heart problems	☐ ________
Brain injury	☐ ________	High or low blood pressure	☐ ________
COPD	☐ ________	Learning disorder	☐ ________
Cancer	☐ ________	Liver disease	☐ ________
Developmental/behavior Disorder(s)	☐ ________	Schizophrenia	☐ ________
Diabetes	☐ ________	Thyroid disease	☐ ________
Eating disorder(s)	☐ ________	Stroke	☐ ________
Tourette Syndrome	☐ ________	Vision or eye problems	☐ ________

OPERATIONS: *Please list year, operation, and surgeon (if known)*

1. ____

2. ____

3. ____

4. ____

FAMILY HISTORY:

Relationship	Illness	Diagnosis Age	Deceased?
Mother:	___________________________________	___________	Y ☐ N ☐
Father:	___________________________________	___________	Y ☐ N ☐
Grandmother (P):	________________________________	___________	Y ☐ N ☐
Grandfather (P):	________________________________	___________	Y ☐ N ☐
Grandmother (M):	________________________________	___________	Y ☐ N ☐
Grandfather (M):	________________________________	___________	Y ☐ N ☐
Brothers:	_________________________________	___________	Y ☐ N ☐
Sisters:	_________________________________	___________	Y ☐ N ☐
Children:	_________________________________	___________	Y ☐ N ☐

REPRODUCTIVE HISTORY:

Number of pregnancies: ___________ Number of children: ___________

Age at first pregnancy: ____________ Did you breast feed? ___________

Age at first period: ___________ Age at menopause: ___________

Age of last period: ___________

Hysterectomy: ☐ Yes ☐ No Ovaries Intact? ______________

Hormone use: ☐ Yes ☐ No

Smoking history

Cigarettes ☐ How many years? _________________________________

Cigars ☐ Number per day _________________________________

Pipes ☐ If quit, when __________________________________

Alcohol history

Beer ☐ How many years? ______________________________

Wine ☐ How much per day/week/month? _______________

Liquor ☐ If quit, when__________________________________

Recreational drug use ☐ Blood transfusions ☐ HIV testing ☐

ALLERGIES TO MEDICATIONS: *please write "none" if none*

Name of drug(s)/type of reaction:

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

MEDICATIONS/SUPPLEMENTS: *please include over the counter drugs*

Name of drug	Dose (mg or mcg)	How many times daily	How long taking for

ADDITIONAL NOTES: *Please use this space to complete any additional notes that were not completed above. Please mark what section they correspond to.*

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Patient signature: ____

Patient printed name: ____Date: ____________