Medical History Form Date:________________________________

Name:________________________________DOB_____________________Age______Gender______

Phone________________________________Email____

Allergies____

How did you hear about the Infusion Center/Services?____

Referring Provider:______________________________________Phone____________________

Primary Care Provider:___________________________________Phone____________________

Mental Health Providers:_________________________________Phone____________________

ALLERGIES

Medication/Supplement/Food	Reaction
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

PAST MEDICAL HISTORY

Do you have any of these conditions? *Check appropriate box and provide date of onset*

= Past Condition *= Current Condition*

NEUROLOGIC / MOOD

- ☐ ☐ Depression______________________________
- ☐ ☐ Anxiety______________________________
- ☐ ☐ PTSD______________________________
- ☐ ☐ Insomnia______________________________
- ☐ ☐ Schizophrenia______________________________
- ☐ ☐ Hallucinations______________________________
- ☐ ☐ ADD/ADHD______________________________
- ☐ ☐ Suicidal______________________________

____

- ☐ ☐ History of Mental Health Crises____________

____

- ☐ ☐ Seizures______________________________
- ☐ ☐ Stroke______________________________
- ☐ ☐ Neuromuscular Disease____________________
- ☐ ☐ History of Psychiatric Admission__________

____

- ☐ ☐ Other______________________________

METABOLIC / ENDOCRINE

- ☐ ☐ Hypothyroid (underactive)________________
- ☐ ☐ Hyperthyroidism (overactive thyroid)________
- ☐ ☐ Other______________________________

____

RESPIRATORY

- ☐ ☐ Shortness of Breath____________________
- ☐ ☐ Asthma______________________________
- ☐ ☐ Obstructive Sleep Apnea________________
- ☐ ☐ Pulmonary Hypertension________________
- ☐ ☐ Other Lung Disorders__________________

GU /GI

- ☐ ☐ Kidney Disease______________________
- ☐ ☐ Liver Disease______________________
- ☐ ☐ Other______________________________

____

Name:________________________________DOB_____________________Date__________________

CARDIOVASCULAR

☐ ☐ High Blood Pressure
Controlled / Uncontrolled____________________
☐ ☐ Chest Pain____________________
☐ ☐ Heart Murmur____________________
☐ ☐ Heart Attack ____________________
☐ ☐ Valve Disease____________________
☐ ☐ Heart Failure____________________
☐ ☐ Abnormal Heart Rhythm____________________
☐ ☐ Bleeding Disorder____________________
☐ ☐ Other____________________
____

PAIN

☐ ☐ Acute Pain____________________
☐ ☐ Chronic Pain____________________
☐ ☐ Fibromyalgia____________________
☐ ☐ Other____________________
____

INFECTIOUS

☐ ☐ HIV____________________
☐ ☐ Tuberculosis____________________
☐ ☐ Hepatitis____________________
☐ ☐ Other____________________
____

HEMATOLOGY / ONCOLOGY

☐ ☐ Bleeding Disorder____________________
☐ ☐ Cancer (explain)____________________
____
☐ ☐ Other____________________
____
____

OTHER

☐ ☐ Substance Abuse (please circle)
Marijuana Cocaine Methamphetamine
Heroin Ketamine
Other Recreational drugs____________________
Last Use____________________
☐ ☐ History of assault____________________
☐ ☐ History of violent behavior____________________
____
____
☐ ☐ Other____________________
____
____
____
____
____
____

PAST SURGICAL HISTORY ☐ None

____
____
____

Name:________________________________DOB_____________________Date_________________

CURRENT MEDICATIONS / SUPPLEMENTS ☐ None

NAME / DOSE	Reason For Use

I am currently compliant with all medications prescribed by my mental health provider

☐**Yes** ☐**No** **If no, please explain:**____

____

____

Patient Signature_______________________________________Date______________Time________