

BIO-BEHAVIORAL MEDICAL CLINICS, INC.

Medical History

Name: _____ Age: _____ Date of Birth: _____

Personal Physician: _____

Last Medical Exam: _____

List all medications you are currently taking and doses, if known:

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Who prescribed the medications? _____

List any medical problems you are currently experiencing: _____

Have you been seen by a physician for these problems? Yes No

If YES, by whom? _____

Please check any of the following problems which may pertain to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Sleeping Difficulty | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Alcohol Use/Abuse | <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Panic/Anxiety |
| <input type="checkbox"/> Drug Use/Abuse | <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Lack of Concentration | <input type="checkbox"/> Suicide Attempts | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Marital/Family Problems | <input type="checkbox"/> Lack of Energy |
| <input type="checkbox"/> Allergies to Medications | <input type="checkbox"/> Dysfunctional Relationship | <input type="checkbox"/> Crying Spells |
| <input type="checkbox"/> Internet/Gaming Problems | <input type="checkbox"/> Pornography Problems | <input type="checkbox"/> Pain |
| <input type="checkbox"/> History of Physical or Sexual Abuse / Assault | | |

Have you received psychiatric help or counseling of any kind before? Yes No

If yes, when, and please explain the nature of your consultation: _____

Have you received treatment for alcohol or drug abuse/dependence? Yes No

If yes, when, and please explain the nature of your treatment, including current status: _____

Is your visit today court ordered? Yes No If yes, please provide details:

Is your visit today work-related? Yes No

Date Completed: _____