

Medical Research Group of Central Florida and Family Psychiatric Services Patient History Form

Patient Name:		Date of Birth:	
Age:	Height:	Weight:	Gender:
Social Security #:		Race:	
Home or Mailing Address:			
City:		State:	Zip Code:
Home Phone: ()		Business Phone: ()	
Cell Phone: ()		Other Phone: ()	
Email:		Referred by:	
Emergency Contact:		Phone #: ()	

PRESCRIPTION MEDICATIONS

Medication	Dose	How Often	Date Started	Taken for What	Last Dose
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /

OVER-THE-COUNTER, VITAMIN AND HERBAL MEDICATIONS

Medication	Dose	How Often	Date Started	Taken for What	Last Dose
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /
			/ /		/ /

Medical Research Group of Central Florida and Family Psychiatric Services Patient History Form

Patient Signature: _____ Date: _____

LIFESTYLE HISTORY			
Have you ever smoked? <input type="radio"/> No <input type="radio"/> Yes : Number smoked per day:			
Date Started:	/ /	Date Stopped:	/ / <input type="radio"/> Ongoing
Do you drink alcoholic beverages? <input type="radio"/> No <input type="radio"/> Yes : How often:			
Do you a history of substance abuse? <input type="radio"/> No <input type="radio"/> Yes : What substance:			
CHILDHOOD ILLNESS AND ALLERGY			
Childhood Illnesses	Date	Allergies	Date
<input type="radio"/> Measles	/ /	<input type="radio"/> Latex	/ /
<input type="radio"/> Mumps	/ /	<input type="radio"/>	/ /
<input type="radio"/> Chicken Pox	/ /	<input type="radio"/>	/ /
<input type="radio"/> Rubella	/ /	<input type="radio"/>	/ /
<input type="radio"/> Scarlet Fever	/ /	<input type="radio"/>	/ /
<input type="radio"/> Rheumatic Fever	/ /	<input type="radio"/>	/ /
SURGICAL / HOSPITALIZATIONS			
Please indicate any surgeries or hospitalizations you have had:			
Surgery/Hospitalization	Date	Reason for surgery/hospitalization:	
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
Current Physicians			
Physician's Name	Specialty	Address	Phone Number
Litigation			

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Are you currently involved in any litigation regarding a medical condition or injury? No Yes :
If Yes, please explain:

Patient Signature: _____ Date: _____

Review of Systems				
Please indicate if you have had any of the following:				
Skin	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> Hives	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Psoriasis	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Eczema	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Rosacea	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Acne	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing
Eyes	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> Glaucoma	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Diabetic Retinopathy	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Macular Degeneration	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing
Ear, Nose and Throat	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> Impaired Hearing	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Chronic Sinusitis	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Rhinitis	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Seasonal or Environmental Allergies <small>(circle one or both)</small>	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing
Gastrointestinal	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> Heartburn	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Ulcers	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> GERD	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Crohn's Disease	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Irritable Bowel Syndrome	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Diverticulosis / Diverticulitis <small>(Circle one or both)</small>	/ /	/ /	OR	<input type="radio"/> Ongoing

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<input type="radio"/> Other: _____	/ /	/ /	OR	<input type="radio"/> Ongoing
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Patient Signature: _____ Date: _____

Review of Systems				
Please indicate if you have had any of the following:				
Respiratory	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> Asthma	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Bronchitis	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> COPD	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Emphysema	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Pneumonia	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Sleep Apnea	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Tuberculosis	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing
Musculoskeletal	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> Osteoarthritis	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Rheumatoid Arthritis	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Fibromyalgia	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Back Pain / Problems	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing
Cardiovascular	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> Angina	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Heart Attack	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> High Blood Pressure	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> High Cholesterol	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing
Endocrine	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> Diabetes Type I or Type II (Circle one)	/ /	/ /	OR	<input type="radio"/> Ongoing

Medical Research Group of Central Florida and Family Psychiatric Services Patient History Form

<input type="radio"/> Hyperthyroidism	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Hypothyroidism	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing

Patient Signature: _____ Date: _____

Review of Systems				
Please indicate if you have had any of the following:				
Neurological / Psychological	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> Anxiety	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Depression	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Insomnia	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Seizure Disorder	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> ADD / ADHD <small>(Circle one)</small>	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Schizophrenia	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Bipolar Disorder	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Alzheimer's Disease	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Migraine Headaches	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Stroke	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing
Hematologic	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> Anemia	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Clotting Disorder	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Phlebitis / Thrombophlebitis	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing
Immunologic	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> HIV / AIDS	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Cancer	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Lupus	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Other:	/ /	/ /	OR	<input type="radio"/> Ongoing
Hepatic / Renal/ Urogenital/ Gynecological	Start Date	Stop Date	OR	Ongoing
<input type="radio"/> Kidney Stones	/ /	/ /	OR	<input type="radio"/> Ongoing

Medical Research Group of Central Florida and Family Psychiatric Services Patient History Form

<input type="radio"/> Liver Disease	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Hepatitis A B or C (Circle one)	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Erectile Dysfunction	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Gynecological Disorder	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/> Sexually Transmitted Disease	/ /	/ /	OR	<input type="radio"/> Ongoing

Patient Signature: _____ Date: _____

ANY OTHER MEDICAL CONDITIONS				
Please include any other medical conditions not previously listed:				
Diagnosis	Start Date	Stop Date	OR	Ongoing
<input type="radio"/>	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/>	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/>	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/>	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/>	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/>	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/>	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/>	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/>	/ /	/ /	OR	<input type="radio"/> Ongoing
<input type="radio"/>	/ /	/ /	OR	<input type="radio"/> Ongoing

BIRTH CONTROL METHODS AND MENSES			
Birth Control Method		Females Only	
<input type="radio"/> Abstinence		Date of Last Period	/ /
<input type="radio"/> Birth Control Pills		Age of Onset	
<input type="radio"/> Double Barrier			
<input type="radio"/> Hysterectomy			
<input type="radio"/> Vasectomy			

CLINICAL TRIAL PARTICIPATION
Have you participated in a clinical trial within the last 60 days? <input type="radio"/> No <input type="radio"/> Yes :
If Yes, when and where:

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Patient Signature: _____ Date: _____

Coordinator Signature: _____ Date: _____