Riverside University Health System - Behavioral Health
ADULT MEDICAL HISTORY SUMMARY

Part I - TO BE COMPLETED BY PATIENT OR PATIENT INFORMANT (Please Print)

Patient's Name: _____
(First) (Middle) (Last) (Maiden)

Name of Informant if other than Patient/Relationship: _____

Current Physician: _____
(Name) (Address/City)

Date of Last Physical: _____ Do you have allergies? ☐Yes ☐No

PLEASE CHECK ALL OF THE FOLLOWING WHICH YOU HAVE HAD IN THE PAST:

☐Heart Problems	☐Drug Use	☐Liver Problems
☐Shortness of Breath	☐Cancer/Immune Disease	☐Hepatitis/Jaundice
☐Pain/Pressure in Chest	☐Frequent/Severe Headache	☐Diabetes
☐High Blood Pressure	☐Head Injury	☐Tuberculosis (TB)
☐Stomach Problems	☐Stroke	☐Sexually Transmitted Disease
☐Alcohol Use	☐Epilepsy/Convulsions	☐Asthma/Hay Fever/Hives/Rash
☐Dizziness/Fainting	☐Kidney Problems	☐Bedwetting/Soiling
☐Seizures	☐Thyroid Problems	☐Unusual Bleeding
☐PMS/Hormone	☐Therapy	☐Pregnancy

OTHER SERIOUS ILLNESS AND/OR MEDICAL TESTS: _____

_____

_____

SUBSTANCES YOU ARE ALLERGIC TO: _____

_____

_____

DESCRIPTION OF ALLERGIC RESPONSE/NATURE OF REACTION: _____

_____

_____

WITHIN THE PAST YEAR HAVE YOU TAKEN PRESCRIBED OR OTHER MEDICATIONS FOR:

Sleep Disturbance? Name: _____ Currently Using? ☐Yes ☐No

Nutrition/Weight Problem? Name: _____ Currently Using? ☐Yes ☐No

Nerves/Anxiety/Depression? Name: _____ Currently Using? ☐Yes ☐No

Pain? Name: _____ Currently Using? ☐Yes ☐No

Consumer Name:_____

Recreation/Relaxation? Name: _____Currently Using? ☐Yes ☐No

Are you taking, or have you taken Antabuse? ☐Yes ☐No

Consumer Signature: _____ **Date:** _____

Consumer Name:_____

Part II - HISTORY TAKING FOR STAFF USE ONLY (Use Additional Sheets if Necessary)

1. SIGNIFICANT PAST ILLNESS, ACCIDENTS, HOSPITILIZATION, and MEDICAL PROBLEMS:

_____

_____

2. SIGNIFICANT FAMILY HEALTH HISTORY AND PROBLEMS: _____

_____

3. SIGNIFICANT CURRENT MEDICAL PROBLEMS: _____

4. CURRENT PSYCHOTROPIC MEDICATION:

Name	Strength /Dose	Duration of Use

5. PAST PSYCHOTROPIC MEDICATION:

Name	Strength /Dose	Duration of Use	Adverse Reachtions? (Yes/No)	
			☐Yes	☐No
			☐Yes	☐No
			☐Yes	☐No

6. OTHER CURRENT MEDICATIONS (Includes Prescription and Non-Prescriptive Drugs):

Name	Strength /Dose	Indication

7. CURRENT USE OF ALCOHOL AND/OR STREET DRUGS:

Name	Frequency Amount

8. PAST USE OF ALCOHOL AND/OR STREET DRUGS:

Name	Frequency Amount

IF ENTRIES ARE MADE TO EITHER QUESTION 7 OR QUESTION 8, PLEASE COMPLETE DRUG/ALCOHOL ASSESSMENT.

COMMENTS: _____

_____

_____

_____

Consumer Name:_____

Clinician Signature Date

_____ _____

Reviewing Physician Signature Date

_____ _____

Reviewing Physician Signature Date