NOVA SOUTHEASTERN UNIVERSITY

Center for Psychological Studies
Psychology Services Center - Therapy and Testing

File # _____

Adult Medical History

Client Name_____ Date_____
Last First Middle

Date of Birth_____ Sex_____ Age_____ Height_____ Weight_____Date of last physical exam: _____

Name, address, and phone no. of personal physician: _____

_____

___

Name, address, and phone no. of person to notify in case of emergency:_____

_____

___

ALLERGIES: Are you allergic to any medications?_____ Which ones?_____ _____Are you allergic to any food? _____ Bee sting?_____

HAVE YOU EVER HAD (PLEASE CHECK AT RIGHT OF EACH ITEM):

(Check each item)	Yes	No	When	(Check each item)	Yes	No	When
Severe and/or freq. headaches				Arthritis or Rheumatism			
Frequent dizzy spells				Swollen or painful joints			
Severe head injury				Any broken bones			
Difficulty with vision				Loss of leg, arm, finger, toe			
Difficulty with hearing				Gout			
Buzzing or ringing in ears				Bone, joint, or other deformity			
Sinus trouble				Blackout spells			
Allergy to pollen, weeds, dust				Seizures			
Frequent nose bleeds				A stroke			
Severe tooth or gum trouble				Frequent crying spells			
Anemia or blood disease				Trouble sleeping			
Heart disease				Paralysis, polio			
Palpitations or pounding heart				Skin trouble			
Pain or pressure in chest				Stomach ulcers			
High blood pressure				**Frequent indigestion**			
Scarlet fever				**Gall stones or gall bladder trouble**			
Rheumatic fever				**Appendicitis**			
Varicose veins				**Liver disease**			
Phlebitis in legs				**Jaundice (yellow skin/eyes)**			
Blood clots in legs				**Cancer**			
Asthma or wheezing				**Frequent diarrhea**			
Emphysema				**Frequent constipation**			
Pneumonia				**Recent gain/loss of weight**			
Tuberculosis				**Loss of appetite**			
Shortness of breath				**Goiter or thyroid trouble**			
Bladder or kidney infection				**Diabetes**			
Kidney stones				**AIDS**			
Gonorrhea				**AIDS Related Complex**			
Syphilis				**HIV Infection**			
Hernia							

Do you smoke cigarettes?_____ Packs per day_____ No. years

Are you on a special diet? (such as low salt, diabetic, low calorie, etc.)
_____ Type:

Do you wear glasses? **Do you use a hearing aid?** **Do you wear a brace?** **Do you have an artificial limb?** **When did you have your last tetanus shot?**	**List <u>all</u> medications you are presently taking:** **(name, amount, and frequency)**

<u>HOSPITALIZATIONS</u>:

List operations you have had with date and name of hospital and date:

List medical hospitalizations which were not for surgery:

<u>FOR WOMEN</u>: No. of pregnancies No. of miscarriages No. of abortions Do you have an IUD? Do you take birth control pills Are your menstrual periods irregular Age at menopause	<u>SUBSTANCE USE AND HISTORY</u>: Do you use alcohol? ☐ yes ☐ no How much and for how long? Do you use street drugs? ☐ yes ☐ no If "yes", specify name, frequency, and for how long a period of time:

FAMILY HISTORY — Has any blood relation (Parent, brother, sister, other) or husband or wife

Relation	Age	State of Health	If Dead, Cause of Death	Age at Death	(Check each item)	Yes	No	Relationship
Father					Had Tuberculosis			
Mother					Had Syphilis			
Spouse					Had Diabetes			
Brothers and Sisters					Had Cancer			
					Had Kidney Trouble			
					Had Heart Trouble			
					Had Stomach Trouble			
					Had Rheumatism (Arthritis)			
Children					Had Asthma, Hay Fever, Hives			
					Had Epilepsy (Fits)			
					Committed Suicide			

I certify that the above information is true and complete to the best of my knowledge.

Signature of Client:_____ Date:

Reviewed by:_____ Title:_____ Date: