Owens Family Counseling
Medical History Form

Chart #_____

Name_____ Age _____ M_____F_____

Medical History:

Please CHECK those, which you have had or now have. If past history, please give date.

EAR, NOSE, THROAT
- ☐ Sinus infection
- ☐ Strep throat by culture

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic cough
- ☐ Hay fever
- ☐ Mononucleosis
- ☐ Pneumonia
- ☐ Positive tuberculin test
- ☐ Tuberculosis

HEART
- ☐ Heart problems/murmur
- ☐ High blood pressure
- ☐ Rheumatic fever

GASTROINTESTINAL
- ☐ Gallbladder problems or gallstones
- ☐ Hepatitis or jaundice
- ☐ Hernia
- ☐ Intestinal problems
- ☐ Pilonidal cyst
- ☐ Rectal problems
- ☐ Severe or recurrent abdominal pain
- ☐ Ulcer (duodenal or stomach)

SKIN
- ☐ Hives or eczema
- ☐ Serious skin disease

URINARY
- ☐ Frequent or painful urination
- ☐ Kidney or bladder infection
- ☐ Kidney stones
- ☐ Prostate infection
- ☐ Protein, blood or sugar in the urine
- ☐ Urethral discharge

SEXUAL TRANSMITTED DISEASE/INFECTION
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Syphilis
- ☐ Venereal warts

WOMEN'S HEALTH
- ☐ Abnormal Pap smear
- ☐ Breast problems
- ☐ Menstrual problems
- ☐ Pelvic inflammatory disease
- ☐ Pregnancy

NEUROLOGICAL
- ☐ Headaches
- ☐ Migraines
- ☐ Paralysis
- ☐ Seizure disorder or epilepsy
- ☐ Severe head injury or concussion

MENTAL HEALTH
- ☐ Alcohol or drug treatment
- ☐ Anorexia or bulimia
- ☐ Depression
- ☐ Excessive worry and anxiety

ORTHOPEDICS
- ☐ Dislocations of _____
- ☐ Fractures, of _____

OTHER PROBLEMS
- ☐ Diabetes
- ☐ Thyroid
- ☐ Other hormone imbalance
- ☐ Tumor, growth or cancer
- ☐ Chicken pox
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Other _____

Do you have DRUG ALLERGIES? ☐ Yes ☐ No If yes, list _____

Any other allergies: _____

List any medications that you take: _____

List any CURRENT DISEASES OR DISABILITIES which you have and any treatment which you're now receiving:

Are you current on all immunizations? ☐ Yes ☐ No Do you have a living will? ☐ Yes ☐ No

Give dates of your most recent immunizations: Tetanus _____ Tuberculin _____ Skin Test _____

OPERATIONS:

Have you ever had surgery? ☐ Yes ☐ No

List:
- Appendectomy ☐
- Ovaries Removed ☐
- Gallbladder ☐
- ☐ Hysterectomy, (If so, reason _____)
- ☐ Joint Replacement?
- ☐ Bypass (If so, what _____)
- Other: _____

Foreign travel within the last year _____

Do you smoke? ☐ Yes ☐ No If yes, _____ (NUMBER) per day/wk, How long _____ (CIRCLE ONE)

Do you chew tobacco? ☐ Yes ☐ No If yes, _____ (NUMBER) per day/wk, How long _____ (CIRCLE ONE)

Do you drink alcohol? ☐ Yes ☐ No If yes, _____ (DRINKS) per day/wk, How long _____ (CIRCLE ONE)

Recreational drug usage? ☐ Yes ☐ No

Do you have any problems with sexual function? ☐ Yes ☐ No

CHILD/ADOLESCENT ONLY:

Do you have any concerns regarding your child's use of drugs or alcohol? ☐ Yes ☐ No If yes, explain _____

Do you have any concerns about your child being sexually active? ☐ Yes ☐ No If yes, explain _____

Has your child been sexually abused? ☐ Yes ☐ No If yes, explain _____

Vision:

Vision Problems ☐ Yes ☐ No If yes, explain _____

Dental:

Dental Problems ☐ Yes ☐ No If yes, explain _____

_____ Client/Guardian's Signature

_____ Date