BAYCARE BEHAVIORAL HEALTH
MEDICAL HISTORY SELF REPORT

First Name: _____ Last Name: _____ Age. _____

Height: _____ Weight: _____ Pregnant: ☐ Yes ☐ No If "Yes", Are you receiving prenatal care? ☐ Yes ☐ No

Primary care physician: _____Phone #_____ Psychiatrist: _____

Past Prescribed Medications (No longer prescribed):

Medication	Was it Helpful?	**Medication**	Was it Helpful?	**Medication**	Was it Helpful?
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No

Currently Prescribed Medications:

Medication	Is it Helpful?	**Medication**	Is it Helpful?	**Medication**	Is it Helpful?
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No

Allergies or Adverse Reactions to any Meds?	☐ Yes ☐ No	List:

Please check if you (S=Self) or a member of your family (F=Family Member) have had any of the following?

S	F		S	F		S	F		S	F		S	
☐	☐	Emphysema	☐	☐	Diabetes	☐	☐	Glaucoma	☐	☐	Tuberculosis	☐	Venereal Disease
☐	☐	Asthma	☐	☐	Thyroid Disease	☐	☐	Heart Disease	☐	☐	Hypertension	☐	Head Injury
☐	☐	Kidney Problems	☐	☐	Epilepsy	☐	☐	Hearing/Eye Issues	☐	☐	Arthritis	☐	Psychological Testing
☐	☐	Bladder Problems	☐	☐	Liver Disease	☐	☐	Hepatitis	☐	☐	Other: _____		

Please check any symptoms you have had in the last three (3) months?

☐ Shortness of Breath	☐ Fainting	☐ Chest Pain	☐ Intestinal Problems	☐ Bronchitis
☐ Dizziness	☐ Coughing	☐ Bladder Problems	☐ Allergies	☐ Headaches
☐ Seizures	☐ Swelling	☐ Weakness	☐ Light Headedness	☐ Other: _____

Please check any conditions you have had in the <u>past</u> or <u>recently</u>:

Past	Recently		Past	Recently		Past	Recently	
☐	☐	Insomnia	☐	☐	Weight loss or gain	☐	☐	Sexual problems
☐	☐	Appetite changes	☐	☐	Low energy	☐	☐	Thoughts of suicide
☐	☐	Crying spells	☐	☐	Irritability	☐	☐	Nightmares
☐	☐	Repetitive irrational behavior	☐	☐	Obsessions	☐	☐	Memory problems
☐	☐	Trouble concentrating	☐	☐	Indecisiveness	☐	☐	Irrational Fears
☐	☐	Extreme nervousness	☐	☐	Seeing or hearing things that are not real			
☐	☐	Frequent & serious loss of temper						

THIS SECTION APPLIES TO CHILDREN AND ADOLESCENTS ONLY

Immunizations current: ☐ Yes ☐ No If "No", please explain: _____

Are hearing, speech, or vision contributing factors to your child's issue? ☐ Yes ☐ No If "Yes", explain: _____

Age at walking? _____ Age at talking single words? _____ Age at talking sentences? _____

Check if there was prenatal exposure to any listed: ☐ Alcohol ☐ Tobacco ☐ Other Drugs ☐ None

Check all those that apply during infancy or early childhood.

☐ Colicky	☐ Active	☐ Uncoordinated	☐ Did not enjoy being held	☐ Sleeping Problems	☐ Restless
☐ Feeding problems	☐ Head Banging	☐ Accident Prone	☐ Other _____		

_____ _____
Patient/Guardian Signature Date