LIGHTHOUSE HEALTH GROUP, LLC
4600 MILITARY TRAIL, SUITE 103
JUPITER, FL 33458
561-249-7400

PATIENT HISTORY FORM

Date:

NAME: ____ Birthdate
Last First M. I.

Age:____________ Sex: F M

How did you hear about this practice?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS

Drug allergies: No Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Physician initials _______

PAST MEDICAL HISTORY

Do you now or have you ever had:

Diabetes
High blood pressure
High cholesterol
Hypothyroidism
Goiter
Cancer (type) _______________
Leukemia
Psoriasis
Angina
Heart problems

Heart murmur
Pneumonia
Pulmonary embolism
Asthma
Emphysema
Stroke
Epilepsy (seizures)
Cataracts
Kidney disease
Kidney stones

Crohn's disease
Colitis
Anemia
Jaundice
Hepatitis
Stomach or peptic ulcer
Rheumatic fever
Tuberculosis
HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? High school Some college College graduate Advanced degree

Marital status: Never married Married Divorced Separated Widowed Partnered/significant other

What is your current or past occupation?

Are you currently working? : Yes No Hours/week ______ If not, are you retired disabled sick leave?

Do you receive disability or SSI? Yes No If yes, for what disability & how long?____________________________

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:
Maternal Relatives:

Paternal Relatives:

Physician initials _______

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- Recent weight gain; how much____
- Recent weight loss: how much____
- Fatigue
- Weakness
- Fever
- Night sweats

MUSCLE/JOINTS/BONES
- Numbness
- Joint pain
- Muscle weakness
- Joint swelling
- Where?

EARS
- Ringing in ears
- Loss of hearing

EYES
- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

THROAT
- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

HEART AND LUNGS
- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

NERVOUS SYSTEM
- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

STOMACH AND INTESTINES
- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

SKIN
- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

BLOOD
- Anemia
- Clots

KIDNEY/URINE/BLADDER
- Frequent or painful urination
- Blood in urine

Women Only:
- Abnormal Pap smear
- Irregular periods
- Bleeding between periods
- PMS

PSYCHIATRIC
- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulties with sexual arousal
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts
- Paranoia
- Mood swings
- Anxiety
- Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:___________

Pregnancies:______________

Miscarriages:______________

Abortions:_____________

Have you reached menopause? Yes No At what age?

Do you have regular periods? Yes No

Physician initials _______

SUBSTANCE USE					
DRUG CATEGORY (tick mark each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes No
CANNABIS: Marijuana hashish hash oil					Yes No
STIMULANTS: Cocaine crack					Yes No
STIMULANTS: Methamphetamine— speed Ice crank					Yes No
AMPHETAMINES/OTHER STIMULANTS: Ritalin Benzedrine Dexedrine					Yes No
BENZODIAZEPINES/TRANQUILIZERS: Valium Librium Halcion Xanax Diazepam “Roofies”					Yes No
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal Seconal Dalmane Quaalude Phenobarbital					Yes No
HEROIN					Yes No
STREET OR ILLICIT METHADONE					Yes No
OTHER OPIOIDS: Tylenol #2 & #3, 282’S, 292’S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes No
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes No
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes No
OTHER: specify)________________________________ ______________________________ ____________________________________					Yes No

Physician initials _______