PATIENT HISTORY FORM

Please fill out both sides completely and RETURN BY MAIL prior to your appointment to:

BIDHC Chestnut Hill/The Street – Medical Records
25 Boylston Street, Suite 204
Chestnut Hill, MA 02467

PATIENT NAME: _____ DATE OF BIRTH:_____

LIST OF CURRENT MEDICAL PROBLEMS:

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

MEDICATION LIST

Please list all medications you currently take including over the counter medicines, vitamins and herbal supplements.

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

7)_____ 8)_____

SOCIAL HISTORY

Marital Status: Married ____ Divorced ____ Single ____

Name of Spouse: _____ Name of Significant Other:_____

Children: Yes _____ How Many _____ No Children_____

Tobacco use: Current smoker heavy (> 10+/day) ____

Current smoker light (<10/day) ____

Former Smoker ____

Never Smoked ____

Alcohol Use: Yes ____ How many per drinks per week ____

No current alcohol use ____

Past alcohol use (# of years)_____ When alcohol use stopped (year)_____

Recreational Drugs: Yes ____ Per week____ Type of recreational drug _____

History of past recreational drug use: Y / N

Domestic Violence: Do you feel safe at home: Y / N

History of domestic violence in the past: Y / N

Guns in the house: Y / N Locked: Y / N

Depression Status:

Over the past two weeks patient expresses little interest or pleasure: Y / N

Over the past two weeks patient has felt down, depressed, hopeless: Y / N

Patient does not report any symptoms of depression or sadness: Y / N

Patient is already being treated for depression: Y / N

Exercise:

Type of Exercise: _____ Times per week:____

Seat Belt/Vehicle: Always ___ Sometimes ___ Never ___

Bike Helmet: Always ___ Sometimes ___ Never ___

SURGICAL HISTORY:

Year: _____ SURGERY: _____ Year: _____ SURGERY:_____

Year: _____ SURGERY: _____ Year:_____ SURGERY:_____