**MEDICAL PSYCHOLOGY CENTER**

# Medical History

Patient Name: _____ Date of Birth:_____

**Please circle all the symptoms you've ever experienced from the following items:** We will talk about the items you circle during your interview. You will be able to explain in greater detail. This is a worksheet, feel free to add information that you think is important.

**Neurological**: visual disturbance, ringing ears, stroke, mini-stroke (TIA), seizures, traumatic brain injury

**Cardiovascular**: high blood pressure, chest pain, heart failure, high cholesterol, cardiac surgery

**Pulmonary:** shortness of breath, asthma, emphysema, COPD, sleep apnea

**Musculoskeletal:** weakness in muscles, tingling, numbness, problems with balance, difficulty walking

**Psychiatric:** depression, anxiety, suicidal thoughts, suicidal attempts, psychiatric hospitalization, behavior changes

**Sleep problems:** Restless legs, sleep apnea, difficulty falling asleep, difficulty staying asleep

**Other:** Diabetes (most recent A1C_____, morning glucose measurements _____,

How often do you test your blood sugar levels _____)

Cancer-please explain:_____

-what type of treatment did you have?_____

Exposure to toxic chemicals – please explain:_____

Please list any surgical procedures OR procedures which required anesthesia within the last 5 years:_____

_____

_____

_____

Please list all medical conditions currently being treated (or note those above that are current):_____

_____

_____

_____

Other relevant health conditions and or concerns you'd like to discuss during your visit:_____

_____

_____

_____

Please list all medications and over the counter drugs and/or supplements that you take (or provide us with a list):

_____

_____

_____