Cedar Centre Psychiatric Group – Please provide medical information as best you can

Name: _____ DOB: _____ Date:_____
Allergies:_____
Medications (include herbs, supplements, vitamins, over the counter, eye drops, ALL medications please):

_____

_____

Past psychiatric medications:

_____

_____

Hospitalizations/Surgeries (include all medical/psychiatric, year and reason):

_____

_____

_____

Have you ever had the following:
Birth Injury(Blue baby): NO YES(explain): _____
Head injuries: NO YES(explain): _____
Loss of consciousness or concussions? NO YES(explain): _____
Seizures: NO YES(explain): _____
Meningitis or Encephalitis: NO YES(explain): _____
ECT(shock treatments): NO YES(explain): _____
Serious Accidents: NO YES(explain): _____
Do you smoke: NO YES Do you drink alcohol: NO YES
Do you have any problems with the following (if you do, please circle and describe below):
Constitution: Fever, Chills, Sleep problems, Appetite or weight changes
HEENT: Vision, glaucoma, hearing problems, smelling problems, taste or swallowing problems
Blood and Immune: weak immune system, allergies, HIV/Aids, bleeding disorder, lymph disorder, cancer
Neurologic: Headache, Tremor, Dizzy, Numbness, Multiple Sclerosis, Parkinson's, Dementia, Memory problems, Restless legs, Seizures, Stroke, Brain or spinal injury or infection, Pinched nerves
Hormones: Fatigue, Tired, Excessive sweating, Hot flashes, Libido changes, Thyroid, Diabetes, Menopause
Gastrointestinal: Abdominal pain, Nausea, Vomiting, Diarrhea, Constipation, Blood in stools, Hepatitis
Cardiovascular: Chest pain, Palpitations, Heart attacks, Heart murmurs, Heart failure, fatigue with activity
Pulmonary: Asthma, COPD, Emphysema, Chronic cough, Wheezing, Coughing up blood
Rheumatology: Fibromyalgia, Chronic Fatigue, Arthritis, Lupus
Skin: Rashes, Easy bruising, Eczema, Psoriasis, Acne, breast problems
Musculoskeletal: Joint problems, Stiffness, Osteoporosis, Muscle or bone diseases, sciatica
Genitourinary: Kidney problems, Urine problems, blood in urine, prostate problems, genital infection
Other details or problems: _____

_____

Are you pregnant? NO YES Are you intending to become pregnant while in treatment? NO YES

_____ _____

Patient (or Guardian) Signature Provider Signature