# Health History Form

**Name:_____ Today's Date:_____**

**Current Medications (names and doses, including over the counter supplements):**

**Past Psychiatric Medications (previous medications you may have taken for depression, anxiety, bipolar disorder, etc.)**

**Allergies to Medications (including reaction)**

☐ No Known Allergies

**Physical Health History:**
*Please indicate if YOU have a history of the following:*

- ☐ Asthma
- ☐ Arthritis
- ☐ Autoimmune Problems
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Blood Clots
- ☐ Bowel Disease
- ☐ Cancer
  Type:
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Diabetes
- ☐ Head Injury
- ☐ Heart Disease
  Type:
- ☐ Hepatitis
  Type:
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Reflux/GERD
- ☐ Seizures
- ☐ Stroke/CVA
- ☐ Seasonal/Environmental Allergies/Hayfever
- ☐ Thyroid Problems
- ☐ Visual Impairment
- ☐ NONE OF THE ABOVE

**Surgeries (type and year):**