PORTNER COUNSELING GROUP

1800 North Federal Highway, Suite 206
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T: 954-895-6263 F: 954-642-2195
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MEDICAL INFORMATION/HISTORY

Client's name_____ Today's date _____

Medical doctor's name_____

Medical doctor's address_____

Medical doctor's phone number_____ Date of last physical exam_____

Medical History (Write yes or no, appropriate response, or check appropriate item)

Allergies _____Penicillin _____Codeine _____Aspirin _____Other medications (Please list)_____

Medications you are taking for physical/medical conditions_____

Medications you are taking for psychiatric conditions_____

Over the counter medications you are taking such as: vitamins, aspirin, and laxatives_____

Surgical operations_____

Hospital admissions for medical conditions_____

Pregnancies _____Total number _____How many are living now _____abortions/miscarriages _____stillbirths

My last menstrual period began on_____ my periods are _____regular _____excessive _____stopped _____PMS

Birth Control _____pill _____spermicidal _____IUD _____abstinent _____surgical _____condom

_____none _____other, please list_____

Injuries _____adult _____child Please list_____

Infectious diseases _____adult _____child Complications_____

_____gonorrhea _____syphilis _____HIV/AIDS _____Hepatitis please list other_____

Growths _____tumors _____growths _____cancer _____cysts

Alcohol _____yes _____occasionally _____quit _____never complications_____

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Drugs _____yes _____occasionally _____quit _____never complications_____

If you use drugs and/or alcohol what effects do they have on your health? _____

_____

Are you on a special diet? _____yes _____no If yes, what kind? _____

PLEASE CHECK EACH ITEM THAT MIGHT PERTAIN TO YOU

Respiratory System _____cough _____flu _____TB _____bronchitis _____emphysema _____shortness of breath _____asthma

Heart and Blood Vessels _____angina _____heart attack _____stroke _____swelling _____cannot walk far _____sit up to sleep ____nosebleeds ____palpitations _____ bad veins ____phlebitis _____high blood pressure _____irregular pulse or heart beat

Digestive System _____ulcers _____nausea _____vomiting with or without blood _____heartburn _____diarrhea _____jaundice _____constipation _____cirrhosis _____stomachaches _____colitis _____bad teeth/gums

Kidney, Bladder, Genitals _____cystitis ____loss of control _____burning ____sores ____itching _____discharge _____stones ____bloody urine ____P.I.D. ____sterility ____up at night _____frequency _____difficulty starting urination ____impotent _____concern about sex organs _____bed wetting

Bones, Muscles, Joints _____arthritis _____brittle bones _____aches _____weakness _____deformity _____need artificial placement _____difficulty bending _____difficulty lifting _____fractures _____skull surgery or fracture ____amputation

Nervous System _____headaches _____dizziness _____abnormal movements _____vertigo _____numbness _____paralysis _____fainting ____seizures _____amnesia _____confusion _____spasms _____strange sensations _____tremors or shakes _____epilepsy

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Skin	_____rash _____itch _____sores _____skin cancer _____new or changing mole or lump _____reaction to the sun
Blood	_____anemic _____low white blood count ____blood disease _____bleed or bruise easily _____blood poisoning
Glands, Metabolism	_____diabetes _____abnormal blood sugar _____thyroid problem ____goiter _____hormone problems _____weight
The Five Senses	Difficulty with _____seeing _____hearing _____smelling _____tasting _____feeling _____I wear or need glasses _____I wear or need a hearing aid _____I have glaucoma _____I had a glaucoma test _____I have never had glaucoma test _____cataracts

Family History **(State which relative may have had the following)**

Mental Illness	_____	Hypertension	_____
Mental Retardation	_____	Alcoholism	_____
Epilepsy	_____	Heart Disease	_____
Tuberculosis	_____	Cancer	_____
Drug Abuse	_____	Kidney Disease	_____
Diabetes	_____	Other	_____
Stroke	_____		

(continued)

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Other Medical concerns you feel it is important we know about that weren't discussed in the previous sections

_____
_____
_____
_____

_____ _____

Client Signature **Date**

_____ _____

Parent/Guardian Signature **Date**