AFFILIATES IN CLINICAL SERVICES, PC
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MEDICAL BIOGRAPHICAL INFORMATION FORM - ADULT

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank. *This information is strictly confidential*.

Personal History

1) Name: _____
2) Age: _____
3) Gender: ☐ M ☐ F
4) Social Security Number: _____
5) Weight: _____
6) Height: _____
7) Eye color: _____
8) Hair color: _____
9) Race: _____
10) Date of Birth: _____
11) Years of education: _____
12) Occupation: _____
13) Present Marital Status:

☐ Single ☐ Divorced ☐ Committed relationship
☐ Separated ☐ Living together ☐ Domestic partnership
☐ Married ☐ Widowed ☐ Other (specify)_____

14) If married/committed, are you living with your spouse/partner at present?: Yes ☐ No ☐
15) If married/committed, years married/committed to present spouse/partner: _____
16) Any children? Yes ☐ No ☐ If yes, Gender/Age(s) _____

Psychological/Psychiatric History

17) What is (are) your main reason(s) for this visit? _____
_____
_____
18) How long has this problem persisted, from 17)? _____
_____
19) Are you receiving psychological/psychiatric services at present? Yes ☐ No ☐
If Yes, please briefly describe treatment and current response: _____
_____
20) Have you received psychological/psychiatric services in the past? Yes ☐ No ☐
If Yes, please briefly describe treatment and response: _____
_____
21) Under what conditions do your problems usually get worse? _____
_____
22) How did you hear about this clinic, or who referred you? _____
_____

23) Please complete the Health History below.

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area below, if you are not having any difficulties, please check "no Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask your provider.

Const. (health in general) ☐ No Problems, or: Lack of energy, unexplained weight gain, unexplained weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer, or other: _____

Ears, Nose, Mouth & Throat ☐ No Problems, or: Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness, or other: _____

C-V (heart & blood vessels) ☐ No Problems, or: Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs, or other: _____

Resp. (lungs & breathing) ☐ No Problems, or: Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray, or other: _____

GI (stomach & intestines) ☐ No Problems, or: Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, change in bowel habits, incontinence, or other: _____

GU (kidney & bladder) ☐ No Problems, or: Painful urination, frequent urination, urgency prostate problems, bladder problems, impotence, or other: _____

MS (muscles, bones, joints) ☐ No Problems, or: Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain, or other: _____

Integ. (skin, hair & breast) ☐ No Problems, or: Persistent rash, itching, new or change in skin lesion, hair loss or increase, breast changes, or other: _____

Neurologic (brain & nerves) ☐ No Problems, or: Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss, or other: _____

Psychiatric (mood & thinking) ☐ No Problems, or: Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions, or other: _____

Endocrinologic (glands) ☐ No Problems, or: Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive, or other: _____

Hematologic (blood/lymph) ☐ No Problems, or: Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas, or other: _____

Allergic/Immunologic ☐ No Problems, or: Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV, or other: _____

Medication allergies/ Adverse reactions ☐ No Problems, or: List details: _____

_____

Continued on next page:

MEDICATIONS List medications you are currently taking
Pharmacy Name _____ Phone _____

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if, your blood relatives had any of the following: Disease	Relationship to you
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Diabetes	
					☐ Heart Disease, Strokes	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐Yes ☐No
If yes, please give approximate dates: _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Birth Year	Birth Sex	Complications if any

HEALTH HABITS Check (√) which substances used and how much

☐	Caffeine	
☐	Tobacco	
☐	Drugs	
	Other	
☐		
☐		

OCCUPATIONAL Check (√) if your work exposes you to the following:

☐	Stress
☐	Hazardous Substances
☐	Heavy Lifting
☐	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my health care professional or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____
Reviewed By Date

Epworth Sleepiness Scale (ESS)

The ESS is a validated, subjective questionnaire used by health care professionals to screen patient fore excessive sleepiness.

24) Rate your sleepiness for each of the following situations using this scale:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

____ Sitting and Reading	____ Lying down to rest in the afternoon when circumstances permit
____ Watching TV	____ Sitting and talking to someone
____ Sitting inactive in a public place (e.g., a theater or meeting	____ Sitting quietly after a lunch without alcohol
____ As a passenger in a car for an hour without a break	____ In a car, while stopped for a few minutes in traffic

Symptoms

25) Check the behaviors and symptoms that occur to you more often than you would like them to take place:

☐ aggression	☐ fatigue	☐ prescription drug abuse
☐ alcohol dependence	☐ hallucinations	☐ recurring thoughts
☐ anger	☐ headaches	☐ sexual difficulties
☐ antisocial behavior	☐ heart palpitations	☐ sick often
☐ anxiety	☐ high blood pressure	☐ sleeping problems
☐ avoiding people	☐ hopelessness	☐ speech problems
☐ caffeine use	☐ impulsivity	☐ suicidal thoughts
☐ chest pain	☐ irritability	☐ thoughts disorganized
☐ depression	☐ judgment errors	☐ trembling
☐ disorientation	☐ loneliness	☐ withdrawing
☐ distractibility	☐ memory impairment	☐ worrying
☐ dizziness	☐ mood shifts	☐ other (specify)
☐ drug dependence	☐ nicotine/tobacco use	_____
☐ eating disorder	☐ panic attacks	_____
☐ elevated mood	☐ phobias/fears	_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.

_____
_____
_____
_____
_____
_____

Patient Name:_____ **Date of Birth:** _____

Have you ever been treated for mental health related concerns: ☐ **Yes** ☐ **No**

If yes, please indicate if you are currently taking or have previously taken any of the medications listed below:

				If past, please explain why it was stopped
Anafranil (clomipramine)	☐	**current**	☐ **past**	
Abilify (aripiprazole)	☐	**current**	☐ **past**	
Ambien (zolpidem)	☐	**current**	☐ **past**	
Ativan (lorazepam)	☐	**current**	☐ **past**	
Trintellix (vortioxetine)	☐	**current**	☐ **past**	
Buspar (buspirone)	☐	**current**	☐ **past**	
Celexa (citalopram)	☐	**current**	☐ **past**	
Clozaril (clozapine)	☐	**current**	☐ **past**	
Cymbalta (duloxetine)	☐	**current**	☐ **past**	
Depakote (valproic acid)	☐	**current**	☐ **past**	
Desyrel (trazodone)	☐	**current**	☐ **past**	
Effexor (venlafaxine)	☐	**current**	☐ **past**	
Elavil (amitriptyline)	☐	**current**	☐ **past**	
Emsam (selegiline)	☐	**current**	☐ **past**	
Eskalith (lithium)	☐	**current**	☐ **past**	
Fanapt (iloperidone)	☐	**current**	☐ **past**	
Fetzima (levomilnacipran)	☐	**current**	☐ **past**	
Geodon (ziprasidone)	☐	**current**	☐ **past**	
Haldol (haloperidol)	☐	**current**	☐ **past**	
Inderal (propranolol)	☐	**current**	☐ **past**	
Invega (paliperidone)	☐	**current**	☐ **past**	
Klonopin (clonazepam)	☐	**current**	☐ **past**	
Lamictal (lamotrigine)	☐	**current**	☐ **past**	
Latuda (lurasidone)	☐	**current**	☐ **past**	
Lexapro (escitalopram)	☐	**current**	☐ **past**	
Librium (chlordiazepoxide)	☐	**current**	☐ **past**	
Lunesta (eszopiclone)	☐	**current**	☐ **past**	
Luvox (fluvoxamine)	☐	**current**	☐ **past**	
Mellaril (thioridazine)	☐	**current**	☐ **past**	
Navane (thiothixene)	☐	**current**	☐ **past**	

Neurontin (gabapentin)		**current**		**past**	
Norpramin (desipramine)		**current**		**past**	
Pamelor (nortriptyline)		**current**		**past**	
Paxil (paroxetine)		**current**		**past**	
Pristiq (desvenlafaxine)		**current**		**past**	
Prolixin (fluphenazine)		**current**		**past**	
Prozac (fluoxetine)		**current**		**past**	
Remeron (mirtazapine)		**current**		**past**	
Restoril (temazepam)		**current**		**past**	
Rexulti (brexpiprazole)		**current**		**past**	
Risperdal (risperidone)		**current**		**past**	
Saphris (asenapine)		**current**		**past**	
Serax (oxazepam)		**current**		**past**	
Seroquel (quetiapine)		**current**		**past**	
Sinequan (doxepin)		**current**		**past**	
Tegretol (carbmazepine)		**current**		**past**	
Thorazine (chlorpromazine(		**current**		**past**	
Tofranil (imipramine)		**current**		**past**	
Topamax (topiramate)		**current**		**past**	
Tranxene (clorazepate)		**current**		**past**	
Trilafon (perphenazine)		**current**		**past**	
Trileptal (oxcarbazepine)		**current**		**past**	
Valium (diazepam)		**current**		**past**	
Viibryd (vilazodone)		**current**		**past**	
Wellbutrin (bupropion)		**current**		**past**	
Xanax (alprazolam)		**current**		**past**	
Zoloft (sertraline)		**current**		**past**	
Zyprexa (olanzapine)		**current**		**past**	

Do you think your current medications are effective: ☐ **Yes** ☐ **No**

If no, please explain:_____

_____

_____