

SNOW INSIGHT MENTAL HEALTH PLLC

PATIENT NAME _____ DOB ___ / ___ / ___ DATE ___ / ___ / ___

CURRENT MEDICATIONS

(NAME, DOSAGE, REASON FOR USE, PLEASE INCLUDE ANY HERBAL OR SUPPLEMENTS)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

SUBSTANCE USE (LIST ANY SUBSTANCES USED, PAST OR PRESENT, LAST USE)

CIGARETTE USE: ___ YES ___ NO _____ AMOUNT VAPE USE: ___ YES ___ NO _____ AMOUNT

HISTORY OF IV DRUG USE _____

FAMILY HISTORY: ANY BLOOD RELATIVES WITH THE FOLLOWING (CHECK ALL THAT APPLY)

<input type="checkbox"/> ALCOHOLISM	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> PARKINSONS
<input type="checkbox"/> ALZHEIMERS DEMENTIA	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEART PROBLEMS	<input type="checkbox"/> SCHIZOPHRENIA
<input type="checkbox"/> AUTOIMMUNE DISORDERS	<input type="checkbox"/> DRUG USE	<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> SUICIDE
<input type="checkbox"/> BIPOLAR DISORDER	<input type="checkbox"/> GENETIC DISORDERS	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> SUDDEN DEATH
<input type="checkbox"/> CANCER TYPE	<input type="checkbox"/> HALLUCINATIONS	<input type="checkbox"/> LIVER PROBLEMS	<input type="checkbox"/> THYROID PROBLEM

LIVING SITUATION (WHO LIVES AT HOME?): _____

EDUCATION:

CURRENT GRADE LEVEL (MINORS) _____

EDUCATION COMPLETED (ADULTS): ___ HIGH SCHOOL ___ GED ___ SOME COLLEGE

___ COLLEGE DEGREE ___ POST GRADUATE DEGREE ___ TECHNICAL SCHOOL

CURRENT OCCUPATION/EMPLOYMENT: _____

HOW LONG AT CURRENT OCCUPATION: _____

SNOW INSIGHT MENTAL HEALTH PLLC

MEDICAL AND SURGICAL HISTORY QUESTIONNAIRE

PATIENT NAME _____ DOB ___ / ___ / ___ DATE ___ / ___ / ___

MEDICATION ALLERGIES: _____

HEIGHT: _____ WEIGHT: _____

PLEASE INDICATE IF YOU HAVE OR HAVE EVER HAD ONE OF THE FOLLOWING CONDITIONS:

<input type="checkbox"/> ALCOHOLISM	<input type="checkbox"/> FAINTING SPELLS	<input type="checkbox"/> LUNG SURGERY
<input type="checkbox"/> ALZHEIMERS	<input type="checkbox"/> FIBROMYALGIA	<input type="checkbox"/> MANIA
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> GALLBLADDER REMOVAL	<input type="checkbox"/> MEMORY PROBLEMS
<input type="checkbox"/> APPENDIX REMOVAL	<input type="checkbox"/> GENDER AFFIRMING SURGERY/MEDICAL TREATMENT	<input type="checkbox"/> MENSTRUAL PROBLEMS
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> GENETIC DISORDERS	<input type="checkbox"/> MIGRAINES
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> MULTIPLE SCLEROSIS
<input type="checkbox"/> AUTOIMMUNE DISEASE	<input type="checkbox"/> HALLUCINATIONS	<input type="checkbox"/> NUMBNESS OR TINGLING IN LIMBS
<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> HEAD INJUREY/CONCUSSION	<input type="checkbox"/> OSTEOPOROSIS
<input type="checkbox"/> BLOOD CLOTS	<input type="checkbox"/> HEARING PROBLEMS	<input type="checkbox"/> PALPITATIONS
<input type="checkbox"/> BRAIN SURGERY	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> PARKINSONS
<input type="checkbox"/> BREAST SURGERY	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> REPETATIVE MOVEMENTS TICS
<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART ARRHYTHMIA	<input type="checkbox"/> TARDIVE DYSKENSIA
CANCER TYPE:	<input type="checkbox"/> HEART SURGERY	<input type="checkbox"/> ARTHRITIS
<input type="checkbox"/> CARDIAC ARREST	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> SEIZURES
<input type="checkbox"/> CHRONIC BACK PAIN	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> SLEEP APNEA
<input type="checkbox"/> CHRONIC PAIN ANY KIND	<input type="checkbox"/> HIGH CHOLESTEROL	USING CPAP Y OR N
<input type="checkbox"/> CHRONIC CONSTIPATION	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> SPINE SURGERY
<input type="checkbox"/> CHRONIC DIARRHEA	<input type="checkbox"/> GASTRITIS/ULCERS	<input type="checkbox"/> STROKE
<input type="checkbox"/> COLON SURGERY	<input type="checkbox"/> REFUX DISEASE (GERD)	<input type="checkbox"/> THYROID DISEASE
<input type="checkbox"/> CONGESTIVE HEART FAILURE	<input type="checkbox"/> HYSTERECTOMY	<input type="checkbox"/> THYROID SURGERY
<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> JOINT REPLACEMENT	<input type="checkbox"/> TUBAL LIGATION
<input type="checkbox"/> DIABETES TYPE 1	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> DIABETES TYPE 2	<input type="checkbox"/> KIDNEY STONES	<input type="checkbox"/> VASCULAR SURGERY
<input type="checkbox"/> DRUG USE OF ANY KIND	<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> WEIGHT REDUCTION SURGERY
<input type="checkbox"/> COPD/EMPHYSEMA	<input type="checkbox"/> LUPUS	

ANY OTHER SURGERIES OR MEDICAL HISTORY: _____