Stony Brook Medicine

Patient Medical History Form

Name: _____ Date of Birth: ___ /___ / ___ Age: ____ Sex: ____

Pharmacy Name: _____ Pharmacy Address: _____

Primary Care Physician and Therapist
Primary Care Provider:_____ **Therapist:** _____

Past Medical History			
Condition / Disease	**Year**	**Condition / Disease**	**Year**
☐ Anxiety		☐ Narcolepsy	
☐ Depression		☐ Insomnia	
☐ Bipolar		☐ Heart Disease	
☐ Schizophrenic		☐ Hypertension	
☐ Gender Dysphoria		☐ Cancer	
☐ ADHD		☐ Drug Abuse	
☐ OCD		☐ Alcohol Abuse	
☐ PTSD		☐ Other:	
☐ Anorexia / Bulimia / Binge Eating		☐ Other:	

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures			
Operation / Hospitalization / Injury	**Month / Yr**	**Operation / Hospitalization / Injury**	**Month / Yr**
1:		4:	
2:		5:	
3:		6:	

Allergies or Intolerance(s) List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)			
Allergen	**Reaction**	**Allergen**	**Reaction**
1:		4:	
2:		5:	
3:		6:	

Current Medication(s)			
Medication	**Dosage**	**Medication**	**Dosage**
1:		6:	
2:		7:	
3:		8:	
4:		9:	
5:		10:	

Social, Educational and Work History			
Marital Status (Circle One): ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated			
Work Status (Circle One): ☐ Employed ☐ Unemployed ☐ Student ☐ Retired ☐ Disabled			
Employer or School: _____			
Do you drink alcohol?	☐ Yes	☐ No	Number of drinks per week? _____
Are you a smoker?	☐ Yes	☐ No	If yes, how many packs per day? _____
Are you a former smoker?	☐ Yes	☐ No	If yes, what year did you quit? _____
Do you smoke e-cigarettes/Vape?	☐ Yes	☐ No	If yes, how often? _____ What type of substance do you Vape? _____
Do you smoke marijuana?	☐ Yes	☐ No	If yes, how often? _____

Family Medical History					
☐ I am unsure of my family history			☐ I am adopted		
Condition / Disease	**Mother**	**Father**	**Sister**	**Brother**	**Other (Please Specify)**
Please Specify Alive/Deceased, if deceased please specify when and how	☐	☐	☐	☐	☐ _____
Please Specify Date of Birth and/or age of Family Member	☐	☐	☐	☐	☐ _____
☐ Anxiety	☐	☐	☐	☐	☐ _____
☐ Depression	☐	☐	☐	☐	☐ _____
☐ Bipolar	☐	☐	☐	☐	☐ _____
☐ Schizophrenic	☐	☐	☐	☐	☐ _____
☐ ADHD	☐	☐	☐	☐	☐ _____
☐ OCD	☐	☐	☐	☐	☐ _____
☐ PTSD	☐	☐	☐	☐	☐ _____
☐ Anorexia / Bulimia / Binge Eating	☐	☐	☐	☐	☐ _____
☐ Cancer	☐	☐	☐	☐	☐ _____
☐ Heart Disease	☐	☐	☐	☐	☐ _____
☐ Diabetes	☐	☐	☐	☐	☐ _____
☐ Other:	☐	☐	☐	☐	☐ _____
☐ Other:	☐	☐	☐	☐	☐ _____

Additional Note(s)