MEDICAL INFORMATION AND HIST0RY
Tenley Fukui, MA, LPC

Name _____ Height _____ Weight ____ Age ___ Date _____

History of Present Illness
Why are you seeing the counselor today? _____
_____

Has any other physician/counselor treated you for this problem? _____
_____
If yes, who and when? _____
_____
If you need additional space please write on the back of this paper.

Is this problem the result of an injury or accident? Yes No If yes, please give the date and details of injury and/or accident. _____
_____
_____
Please write on the back of this page if you need more room.
Past Surgical History: Please list all previous surgical procedures: _____
_____
_____
_____

If you need additional space please write on the back of this paper.
Please list all implants, pacemakers, artificial joints and/or metal in the body:_____
_____

Medications: Please list all medications including over the counter and herbal.
Name of Medication Strength Frequency

_____
(Please list additional medications on the back)

Do you take Aspirin Yes No, Coumadin Yes No, Blood thinners Yes No, Anti-inflammatory medicine Yes No

Allergies to medication None Penicillin Codeine Other, Please list medication and reaction.

Health Habits
Caffeine use? Yes No How much? _____
Cigarettes Yes No If yes # packs per day _____ for how many years _____?
If you quit, when _____. Oral tobacco and/or snuff Yes No
For how long? _____
Alcohol Yes No Type _____Amount _____ Frequency _____
Drugs Yes No Type _____
Amount_____ Frequency _____

Family Medical History: List relation, medical condition, and age. If deceased, cause and age at death.

	Age	Health	Cause of death
Mother			
Father			
Sister(s)			
Brother(s)			
Step relatives			

Is there any other medical information you feel we should be aware of?

Review of Systems Please check all that apply. If it occurred in the past put a P next to the box.

Headaches	Blood in stool	Toe/Foot Infection
Change in vision	Black Stools	Numbness
Difficulty breathing	Leg cramps	Tingling
Hoarseness	Kidney stone	Dizziness
Difficulty swallowing	Difficult urination	Noise in ears
Chest pain	Burning with urination	Neck pain
Shortness of breath	Rash	Loss of hearing
Heartburn	Stroke	Constipation
Foot/leg cramps	Back pain	Diarrhea

Other Conditions or devices:

Addiction	Breast lump	Epilepsy
AIDS	Bronchitis	Fibromyalgia
Alcoholism	Bulimia	Glaucoma
Anemia	Cancer	Goiter
Anorexia	Cataracts	Gout
Appendicitis	Celiac disease	Gonorrhea
Arthritis	Chicken Pox	Heart Disease
Asthma	Diabetes	Hepatitis
Bleeding disorder	Emphysema	Hernia

Herpes	Liver disease	Prostate problem
High cholesterol	Migraine	Spinal cord stimulator
HIV positive	Miscarriage	Stomach ulcers
Hypertension	Morphine Pump	Thyroid problems
Irritable bowel syndrome	Multiple sclerosis	Tuberculosis
	Pacemaker	Venereal disease
Kidney disease	Polio	

Psychiatric care If so, when and with whom? _____
_____

Psychological care If so, when and with whom? _____
_____

I certify that the above information is correct to the best of my knowledge. I will not hold my counselor responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of patient Date