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### **Patient History**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Marital status: \_\_\_\_\_ Children's ages (if any): \_\_\_\_\_

History of chronic illnesses (e.g., high blood pressure, diabetes): \_\_\_\_\_

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History of surgeries: \_\_\_\_\_

Medications:

Name

Dosage and frequency

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Allergies: \_\_\_\_\_

Alcohol:

On average, how many days per month do you drink? \_\_\_\_\_

On average, how many standard drinks (12 oz. beer, 5 oz. wine, 1.5 oz. liquor) do you have on days that you drink? \_\_\_\_\_

Do you smoke cigarettes? No \_\_\_\_\_ Yes \_\_\_\_\_, \_\_\_\_\_ packs per day

Other substances (which, how much, how often): \_\_\_\_\_

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Who lives in your home? \_\_\_\_\_

Occupation: \_\_\_\_\_

Education: \_\_\_\_\_

Family history of mental illness: \_\_\_\_\_

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Family history of addiction: \_\_\_\_\_

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Today's date: \_\_\_\_\_