WICHITA PSYCHIATRIC CONSULTANTS

Medical History

Date:___________________________________

Patient Name:____ **Date of Birth**_____________________

Reason for Visit:____

Have you ever received Mental Health Treatment? _______Yes _______No

If yes, please list treating physician:

____

Physician or Clinic Address Phone

When was this treatment received?____

Were medications prescribed by this physician? _______Yes _______No

If yes, please list medications:

Medication **Prescribed By**

____

____

____

____

May we request medical records from this physician? _______Yes _______No

If yes, please ask receptionist for a Release of Information

Date of last physical:____

Who performed your last physical?____

Do you have any chronic medical problems? _______Yes _______No

If yes, please list:____

____

Do you drink alcohol? _______Yes _______No

Frequency of use_______________________________________ Amount of Use_____________________

Are you currently taking any over the counter medications? _______Yes _______No

If yes, please list____

____

Medical Problems (check all that apply for you and your family)

	Self	Family
Diabetes	_______	_______
Hypertension	_______	_______
Cancer	_______	_______
Epilepsy/Seizures	_______	_______
Asthma	_______	_______
Heart Disease	_______	_______
Stroke	_______	_______
Lung Disease	_______	_______
Headaches/Migraines	_______	_______
Arthritis	_______	_______
Depression	_______	_______
Anxiety	_______	_______
Mental Illness	_______	_______

Known Allergies:____

____

Are you currently taking any medications prescribed by a physician? _______Yes _______No

If yes, please list medication and prescribing physician

Medication	**Dosage**	**Prescribed By**

Please list any additional information that you feel would be helpful for the physician to know regarding today's visit:

____

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