COLUMBIA COMMUNITY MENTAL HEALTH
MEDICAL DATA BASE

NAME:_____Age:_____Sex:_____Hgt:_____Wgt:_____Date:_____

Daytime phone # _____ Zip Code: _____

Family Physician:_____ Phone #_____Date of last exam: _____

Illnesses and Disorders

	Self	Related Family		Self	Related Family
Heart Disease	☐	☐	High blood pressure	☐	☐
Anemia	☐	☐	Thyroid disorder	☐	☐
Emphysema	☐	☐	Asthma	☐	☐
Liver Disease	☐	☐	Cirrhosis	☐	☐
Hepatitis	☐	☐	Cancer	☐	☐
Arthritis	☐	☐	Muscle Pain	☐	☐
Stomach Pain	☐	☐	Bowel problems	☐	☐
Diabetes	☐	☐	Kidney/Bladder	☐	☐
Mental Illness	☐	☐	Substance Abuse	☐	☐
Head Injury	☐		Other	☐	☐

Please explain:

_____

Do you have problems with the following:

☐ Hearing ☐ Vision ☐ Dental ☐ Ambulation

☐ Sleep ☐ Diet ☐ Sexual ☐ Menstrual periods

Please explain:

_____

Current Medications Dose Frequency Prescribed by ***(name of physician.)***

_____

_____

_____

_____

_____

_____

Are you allergic to any medications? ☐Yes ☐No If yes please list name: _____
Symptoms of Allergy:

_____

History of seizure? ☐Yes ☐No Date of last Seizure:_____ Frequency of seizures:_____

Describe your seizures: _____

Hospitalizations:

Hospital name or address: Date Reason Physician

_____
_____
_____
_____
_____
_____

Children Only: If yes please explain:

Were there problems with the birth? ☐Yes ☐No _____
Were there concerns with the pregnancy? ☐Yes ☐No _____
Were there health concerns after birth? ☐Yes ☐No _____
_____
_____

Substance use:

Tobacco? ☐Smoke ☐Chew ☐Neither Number of years? _____ How many per day? _____
Persistent cough or shortness of breath? ☐Yes ☐No
Sores in mouth? ☐Yes ☐No

Do you drink caffeinated beverages? ☐Yes ☐No Amount per day _____

Do you drink alcohol? ☐Yes ☐No Amount per day _____week _____month _____

Do you use marijuana? ☐Yes ☐No ☐As prescribed Amount per day _____month _____

Do you use other drugs? [Including misusing prescribed drug?] ☐Yes ☐No What drug? _____
How? ☐ IV ☐ Inhale ☐ Pills ☐ Smoke

Have you abused drugs or alcohol in the past? *(Please explain):* _____ _____
_____
_____

Have you ever had blackouts? ☐Yes ☐No *(Please explain):* _____

Please list and explain any other medical concerns you may have: _____

MEDICAL REVIEWER: _____DATE: _____

Comments: _____