Medical History

A Window of Hope Counseling Center/-
Harold W. Anderson LLC

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Harold W. Anderson, Ph.D., LMFT, CAC III, AAMFT Approved Supervisor

Name:

Insurance No./Medicaid No.

Who is you primary care provider (PCP)?

Address of PCP's practice"

PCP's phone, FAX, and Email (if known)

When was your last physical?

If you are filling this out for a child, when was the last well-child exam or Early and Periodic Screening, Diagnostic, Treatment (EPSDT) exam?

If you have not had an exam in the last year, it is strongly recommended you do so before or soon after the beginning of mental health treatment.

- ◯ Yes, I will schedule an exam as soon as possible.
- ◯ I have had an exam within the last year.
- ◯ I do not wish to schedule an exam at this time.

Are you taking any medications currently? (Excluding medications for psychiatric treatment)

- ◯ YES
- ◯ NO

If YES, please include these medications below:

Patient Allergies

Do you have any known allergies to medication?

- ◯ YES
- ◯ NO

List Medication Allergy and Reaction (one per line)

Medical Issues:

Have you a history of any of the following health problems? (Please check all that apply)

- ☐ No Problems
- ☐ Allergies
- ☐ Anemia (low blood count)
- ☐ Arthritis
- ☐ Asthma
- ☐ Back problems (including disk or spine)
- ☐ Cancer
- ☐ Cataracts
- ☐ Chickenpox (as a child)
- ☐ Chronic Bronchitis
- ☐ COPD (Emphysema)
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Fainting spells/ Passing out
- ☐ High cholesterol
- ☐ Fibromyalgia
- ☐ Gall Bladder disease
- ☐ Gastritis or Ulcer
- ☐ Glaucoma
- ☐ Gout
- ☐ Loss of Hearing
- ☐ Heart disease
- ☐ Heart defect from birth
- ☐ Heart valve problems
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ HIV
- ☐ Hypertension (High blood pressure)
- ☐ Hypotension (Low blood pressure)
- ☐ Inflammatory Bowel Disease
- ☐ Iron deficiency
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver disease (other)
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Obesity / Overweight
- ☐ Parkinson's Disease
- ☐ Polyps
- ☐ Seizures
- ☐ Sexually Transmitted Disease (STD)
- ☐ Sleep apnea
- ☐ Stroke/TIA
- ☐ Testosterone (low)

History continued on next page.

Medical History Continued

- [ ] Thyroid problems (hypothyroid/hyperthyroid)
- [ ] Tuberculosis or exposure to tuberculosis

Other:

Have you a history of surgery in any of the following areas? (Please check all that apply)

- [ ] No surgical history
- [ ] Back/Neck
- [ ] Brain
- [ ] Cardiac
- [ ] Ear/Nose/Throat
- [ ] Gall Bladder
- [ ] Hernia
- [ ] Hip/Knee/Ankle/Foot
- [ ] Hysterectomy (Ovaries Removed)
- [ ] Hysterectomy (Ovaries Retained)
- [ ] Intestine
- [ ] Kidney
- [ ] Liver
- [ ] Lung
- [ ] Pancreas
- [ ] Pelvis
- [ ] Penis
- [ ] Prostate
- [ ] Sex Change
- [ ] Shoulder/Elbow/Wrist/Hand
- [ ] Stomach
- [ ] Tonsils
- [ ] Vagina
- [ ] Weight Loss

Other:

Review of Systems

Constitutional

- [ ] Chronic pain
- [ ] Loss of appetite
- [ ] Increase in appetite
- [ ] Unexplained weight loss
- [ ] Weight gain
- [ ] Fatigue/Lethargy
- [ ] Unexplained fever
- [ ] Hot or Cold spells
- [ ] Night sweats
- [ ] Sleeping pattern disruption
- [ ] Malaise (Flu-like or Vague sick feeling)

Eyes

- [ ] Eye pain
- [ ] Eye discharge
- [ ] Eye redness
- [ ] Blurred or double vision
- [ ] Visual change
- [ ] History of eye surgery
- [ ] Sensitivity to light
- [ ] Scotomas (Blind spots)
- [ ] Retinal hemorrhage (Floaters in vision)
- [ ] Amaurosis fugax (Feeling like a curtain is pulled over vision)

Ears, Nose, Mouth, and Throat

- [ ] Earache
- [ ] Tinnitus (Ringing in ears)
- [ ] Frequent ear infections
- [ ] Frequent nose bleeds
- [ ] Sinus congestion
- [ ] Runny nose/Post- nasal drip
- [ ] Difficulty swallowing
- [ ] Frequent sore throat
- [ ] Prolonged hoarseness
- [ ] Pain in jaw or tooth
- [ ] Dry mouth

Other

Other:

Other:

None of the above constitutional issues

None of the above eye issues

None of the above ENMT issues

Cardiovascular

- Chest pain
- Pacemaker
- Palpitations (fast or irregular heartbeat)
- Swollen feet or hands
- Fainting spells
- Shortness of breath with exercise

Respiratory

- Pain with breathing
- Chronic cough
- Chronic shortness of breath
- Chronic wheezing/ Asthma
- Excessive phlegm
- Coughing blood
- Nocturnal Dyspnea (Shortness of breath at night)

Musculoskeletal

- Swelling in joints
- Redness of joints
- Other joint pains or stiffness
- Muscle pain or cramping
- Muscle weakness
- Muscle stiffness
- Decreased range of motion
- Back pain or stiffness
- History of fractures

Other

Other:

Other:

None of the above cardiovascular issues

None of the above respiratory issues

None of the above Muscouloskeletal issues

Gastrointestinal

- Excessive flatulence or belching
- Diarrhea
- Constipation
- Persistent nausea/vomiting
- Abdominal Pain
- Heartburn
- Difficulty swallowing solids or liquids
- Recent loss in appetite
- Sensitivity to milk products
- Jaundice (yellow skin)
- Change in appearance of stool
- Blood in stool
- Dark/Tarry stool
- Loss of bowel control/soiling

Other

None of the above cardiovascular issues

Allergic/Immunologic

- [ ] Frequent infections
- [ ] Hives
- [ ] Anaphylaxic reaction

Other

None of the above **Allergic/ Immunologic** issues

Endocrine

- [ ] Severe menopausal symptoms
- [ ] Cold or heat intolerance
- [ ] Excessive appetite
- [ ] Excessive thirst or urination
- [ ] Excessive sweating

Other:

None of the above Endocrine issues

Hematologic/Lymphatic

- [ ] Blood clots
- [ ] Redness of joints
- [ ] Excess/easy bleeding (surgery, dental work, brushing teeth, scrapes)
- [ ] History of blood transfusion
- [ ] Excessive bruising
- [ ] Swollen glands (neck, armpits, groin)

Other:

None of the above **Hematologic/ Lymphatic** issues

Genitourinary (General)

- [ ] Loss of urine control (including bed- wetting)
- [ ] Painful/Burning urination
- [ ] Blood in urine
- [ ] Increased frequency of urination
- [ ] Up more than twice/night to urinate
- [ ] Urine retention
- [ ] Frequent urine infections

Other

None of the above Genitourinary (General) issues

Genitourinary (Women)

- [ ] Unusual vaginal discharge
- [ ] Vaginal pain, bleeding, soreness, or dryness
- [ ] Genital sores
- [ ] Heavy or irregular periods
- [ ] No menses (Periods stopped)
- [ ] Currently pregnant
- [ ] Sterility/Infertility
- [ ] Any other sexual or sex organ concerns

Other:

None of the above Genitourinary (Women) issues

Genitourinary (Men)

- [ ] Slow urine stream
- [ ] Scrotal pain
- [ ] Lump or mass in the testicles
- [ ] Abnormal penis discharge
- [ ] Trouble getting/ maintaining erections
- [ ] Inability to ejaculate/ orgasm
- [ ] Any other sexual or sex organ concerns

Other:

None of the above Genitourinary (Men) issues

Neurological

- [ ] **Paralysis**
- [ ] **Fainting spells or blackouts**
- [ ] **Dizziness/Vertigo**
- [ ] **Drowsiness**
- [ ] **Slurred speech**
- [ ] **Speech problems (other)**
- [ ] **Short term memory trouble**
- [ ] **Memory difficulties (loss)**
- [ ] **Muscle weakness**
- [ ] **Numbness/Tingling sensations**
- [ ] **Neuropathy (numbness in feet)**
- [ ] **Tremor in hands/shaking**
- [ ] **Muscle spasms or tremors**

Integumentary (Skin/Breast and Hair)

- [ ] **Lesions**
- [ ] **Unusual mole**
- [ ] **Easy bruising**
- [ ] **Increased perspiration**
- [ ] **Rashes**
- [ ] **Chronic dry skin**
- [ ] **Itchy skin or scalp**
- [ ] **Hair or nail changes**
- [ ] **Hair loss**
- [ ] **Breast tenderness**
- [ ] **Breast discharge**
- [ ] **Breast lump or mass**

Psychiatric

- [ ] **Feeling depressed**
- [ ] **Difficulty concentrating**
- [ ] **Phobias/ Unexplained fears**
- [ ] **No pleasure from life anymore**
- [ ] **Anxiety**
- [ ] **Insomnia**
- [ ] **Excessive moodiness**
- [ ] **Stress**
- [ ] **Disturbing thoughts**
- [ ] **Manic episodes**
- [ ] **Confusion**
- [ ] **Memory loss**
- [ ] **Nightmares**

Other

Other:

Other:

None of the above Neurological issues

None of the above Integumentary issues

None of the above **Psychiatric** issues

Are you a smoker?

- ◯ YES
- ◯ NO

If YES, how many packs per day?

When did you begin smoking

Have you ever tried to quit?

- ◯ YES
- ◯ NO

How many times have you tried to quit? What made you start again?

.

The information is accurate to the best of my knowledge

Signed

Date (mm/dd/yy)

Please return this form to the office at least 24 hours prior to your appointment or email it to hwanderson@q.com. Or, you may FAX it to 970-205-9462. If you choose to email it you can go to www.sendinc.com and mail it securely. You will need to set up an account, which is free. Thank you.