OFFICE AND PRACTICE OF J. BERNARD CORDOBA, MD

ADULT HEALTH HISTORY

UPDATED APRIL 2020

Please fill out the following health history form completely. Thank you.

Patient Name_____Date_____

Sex: M F Date of Birth_____Years of Education_____

1. Please describe the reason(s) you are seeking treatment:

_____

_____

_____

2. When did the problem begin and what motivates you to seek treatment now?

_____

_____

3. On the scale below, please estimate the current severity of the problem(s).

_____ _____ _____ _____

mildly upsetting moderately severe very severe totally incapacitating

4. List all past or present mental health treatments:

Dates Type of treatment Doctor/Therapist's Name Where

_____

_____

_____

_____

5. List ALL current medications including herbs, supplements and over the counter agents

_____

_____

6. List ALL medications taken in the past for emotional and psychiatric reasons and dates taken

_____

_____

7. Are you allergic to any medication(s)? (If yes, please list)

_____

8. Mark an X for any of the following that have every applied to you

Medical

_____asthma

_____glaucoma

_____liver disease

_____kidney disease

_____pancreatitis

_____mononucleosis

_____epilepsy

_____thyroid disease

_____cancer

_____heart trouble

_____diabetes

_____venereal disease

_____AIDS or HIV+

_____chronic pain

_____high blood pressure

_____sleep disorder

_____head injury

Mental Health

_____juvenile delinquency

_____school phobia

_____family problems

_____teenage pregnancy

_____bedwetting

_____sexual abuse

_____anorexia

_____binge eating

_____behavioral problems

_____sexual problems

_____sexual identity issues

_____childhood fears

_____hyperactivity

_____running away

_____truancy

_____physical abuse

_____incest

_____rape

Other not mentioned above_____

9. Please list any past or current medical problems or mental illnesses (depression, anxiety, chemical dependency, psychiatric hospitalizations, etc.) incurred by any of your blood related relatives:

_____

_____

10. List any specific requests or special needs that you require

_____

_____

_____ _____ _____

Patient name Patient Signature Date