Chapel Hill Psychiatric Associates, PA

Medical History Update

Name: _____ **Date:** _____

CURRENT MEDICAL CONDITIONS – check box if you have completed this form before and there are no changes ☐

_____

_____

CURRENT MEDICATIONS - check box if you have completed this form before and there are no changes ☐

_____

_____

** COMPLETE ALL OF THE FOLLOWING INFORMATION AT EACH APPOINTMENT**

Current height_____ Weight_____

Please check all current symptoms:

GENERAL
- ☐ Feeling unwell

SLEEP
- ☐ Sleep problems
- ☐ Daytime fatigue
- ☐ Significant snoring
- ☐ Feeling short of breath
- ☐ Other _____

EYES
- ☐ Blurred vision
- ☐ Painful or irritated eyes
- ☐ Other: _____

EARS, NOSE, THROAT AND MOUTH
- ☐ Allergy symptoms
- ☐ Ringing in the ears ☐ Other _____

CARDIOVASCULAR
- ☐ Palpitations/Racing heart
- ☐ Pain in chest
- ☐ Swelling in legs
- ☐ Other _____

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Other _____

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Nausea/vomiting
- ☐ Other: _____

GENITOURINARY
- ☐ Pain when urinating
- ☐ **Pregnancy**
- ☐ Other: _____

MUSCULOSKELETAL
- ☐ Soreness
- ☐ Weakness
- ☐ Cramping
- ☐ Other: _____

INTEGUMENTARY
- ☐ Itchy skin/rash
- ☐ Other: _____

NEUROLOGICAL
- ☐ Headaches
- ☐ Ringing in ears
- ☐ Dizziness/ Vertigo
- ☐ Abnormal movements
- ☐ Imbalance
- ☐ Other: _____

ENDOCRINE
- ☐ Hot Flashes
- ☐ Hair loss/ growth
- ☐ Heat/cold sensitivity
- ☐ Weight gain/loss
- ☐ Other: _____

HEMATOLOGIC
- ☐ Bleeding easily
- ☐ Night sweats
- ☐ Swollen lymph nodes
- ☐ Other: _____

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