PAST MEDICAL HISTORY:

Are you currently being treated for any medical conditions? YES NO

If yes, please list your medical conditions.

Have you ever been hospitalized for any medical conditions? YES NO

Reason:_____ When:_____

Have you ever had surgery? YES NO

Type:_____ When: _____

Have you ever had a seizure? YES NO

Have you ever had a concussion? YES NO

MEDICATIONS:

Are you currently taking any medications? YES NO

If yes, please list medications including dosages.

Do you have any allergies to any medications? YES NO

If yes, please list medication allergies.

FAMILY HISTORY:

Do any family members have problems with:

Psychiatry illness? YES NO

Substance use? YES NO

If yes, please briefly list which family members and give a brief explanation of their mental health problem(s).

Do any medical problems run in your family?

YES NO