Alamir Health Inc.

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MEDICAL HISTORY

ALLERGIES: ________________________________ **NO ALLERGIES:**_______________

Medical conditions that you currently (or in the past) have received treatment for (including surgeries):

____

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____

____

Current medications (include all medications for any condition):

Medication Name **Dose** **Frequency**

______________________ ___________ __________________ ______________________ __________

____ ____

___________ ______________________ ______________________ ___________ __________________

______________________ ___________ ______________________ ______________________ ________

Past psychotropic medications that you have been prescribed:

______________________ _______________________ ______________________ _______________________

______________________ _______________________ ______________________ _________________________

Primary Care Provider and other treating Physicians or Therapists:

Name **Type of Provider** **Phone**

_________________________ ____++_________

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***Psychiatric Hospitalizations Have you ever been Psychiatrically Hospitalized? YES / NO**

If yes, Location(s) and Date(s): ____

______________________________ ______________________________

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*** Substance Abuse Are you currently, or have you in the past, abused nicotine?**

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***Are you currently or have you in the past used, abused, or been dependent on opiates (including pain medications), marijuana, cocaine, or other drugs of abuse?**

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Do you drink alcohol? If so, type, amount, and frequency:

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***This form has been completed to the best of my knowledge and ability.**

__________________________________ ______________

PATIENT SIGNATURE DATE