MEDICAL INFORMATION AND HIST0RY
Tenley Fukui, MA, LPC

Name ___________________ Height _____ Weight ____ Age ___ Date _________

History of Present Illness
Why are you seeing the counselor today? ______________________________________
____

Has any other physician/counselor treated you for this problem? ___________________
____
If yes, who and when? ____
____
If you need additional space please write on the back of this paper.

Is this problem the result of an injury or accident? Yes No If yes, please give the date and details of injury and/or accident. ____
____
____
Please write on the back of this page if you need more room.
Past Surgical History: Please list all previous surgical procedures: ________________
____
____
____

If you need additional space please write on the back of this paper.
Please list all implants, pacemakers, artificial joints and/or metal in the body:________
____

Medications: Please list all medications including over the counter and herbal.

Name of Medication	Strength	Frequency

(Please list additional medications on the back)

Do you take Aspirin Yes No, Coumadin Yes No, Blood thinners Yes No, Anti-inflammatory medicine Yes No

Allergies to medication None Penicillin Codeine Other, Please list medication and reaction.
____
____

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Health Habits

Caffeine use? Yes No How much? ______________________________________

Cigarettes Yes No If yes # packs per day _____ for how many years _____?

If you quit, when __________. Oral tobacco and/or snuff Yes No

For how long? _____________

Alcohol Yes No Type ________Amount __________ Frequency _____________

Marijuana/CBD Yes No Type _______ Amount __________ Frequency ________

Drugs Yes No Type ____

Amount__________________ Frequency ____________________________

Family Medical History: List relation, medical condition, and age. If deceased, cause and age at death.

	Age	Health	Cause of death
Mother			
Father			
Sister(s)			
Brother(s)			
Step relatives			

Is there any other medical information you feel we should be aware of?

Review of Systems Please check all that apply. If it occurred in the past put a P next to the box.

Headaches	Blood in stool	Toe/Foot Infection
Change in vision	Black Stools	Numbness
Difficulty breathing	Leg cramps	Tingling
Hoarseness	Kidney stone	Dizziness
Difficulty swallowing	Difficult urination	Noise in ears
Chest pain	Burning with urination	Neck pain
Shortness of breath	Rash	Loss of hearing
Heartburn	Stroke	Constipation
Foot/leg cramps	Back pain	Diarrhea

Other Conditions or devices:

Addiction	Bleeding disorder	Diabetes
AIDS	Breast lump	Emphysema
Alcoholism	Bronchitis	Epilepsy
Anemia	Bulimia	Fibromyalgia
Anorexia	Cancer	Glaucoma
Appendicitis	Cataracts	Goiter
Arthritis	Celiac disease	Gout
Asthma	Chicken Pox	Gonorrhea

Heart Disease
Hepatitis
Hernia
Herpes
High cholesterol
HIV positive
Hypertension
Irritable bowel syndrome
Kidney disease
Liver disease
Migraine
Miscarriage
Morphine Pump
Multiple sclerosis
Pacemaker
Polio
Prostate problem
Spinal cord stimulator
Stomach ulcers
Thyroid problems
Tuberculosis
Venereal disease

Psychiatric care If so, when and with whom? ________________________
____

Psychological care If so, when and with whom? ______________________
____

I certify that the above information is correct to the best of my knowledge. I will not hold my counselor responsible for any errors or omissions that I may have made in the completion of this form.

_________________________________ _____________________
Signature of patient Date