Pastoral Counseling Services of the South Shore
Brief Medical History Form

Name: _____ **Date:** _____

DOB: _____ **Age:** _____ **Preferred Gender Pronoun(s):** _____

Primary Care Physician: _____ **Phone:** _____

Address: _____

(1) Please list any medical problems you are currently experiencing:

_____

_____

_____

(2) Please list any medications you are currently taking (name, dosage, frequency, prescriber):

_____

_____

_____

(3) Please check any of the following that you experience:

	Change of appetite		Difficulty concentrating		Problem drinking		Recreational drug use
	Headaches		Fatigue		Acute pain		Bowel problems
	Stomach problems		Inattention		Chronic pain		Bladder problems
	Confusion		Chronic fatigue		Thyroid problems		Memory problems
	Sleep disturbance		Chronic medical illness/disease		History of urinary tract infections		History of concussions
	Traumatic brain injury		Neurological events (such as a stroke, aneurysm)		Sexual dysfunction		Other (please specifiy)

(4) Have you ever been hospitalized to treat a physical injury or illness, or a medical disease?

_____

_____

_____

(5) Please list any major surgeries you have experienced in the last 5 years. _____

_____

_____

_____

(6) Have you seen a counselor or a psychiatrist for counseling due to a physical injury or illness, or a medical disease? Who/When/Where: _____

_____

_____

(7) Date of last Medical Examination: _____

Please list any medical concerns you are presently experiencing (e.g., high blood pressure):

_____

_____

Any other relevant medical information? _____

_____

_____