Medical History & Physical Form

Name: _____ Date: _____

DOB _____ Age _____ Gender _____

Phone: cell _____ home _____ Email _____

Primary Care Provider: _____ Phone _____

Mental Health Provider: _____ Phone _____

Referred By: _____ Phone _____

CURRENT MEDICATIONS / SUPPLEMENTS ☐ None

MEDICATION	DOSE	FREQUENCY	TAKEN FOR

ALLERGIES	NKDA ☐	REACTION

I am currently compliant with all medications prescribed by my health providers

☐ Yes ☐ No *If no, please explain:* _____

In your own words please describe what condition you are seeking treatment for

_____

_____

_____

_____

ILLUMINATE KETAMINE CENTER

Name: _____ DOB: _____

PAST MEDICAL HISTORY

Have you ever had or currently have any of the following symptoms? *Circle Those That Apply*

NEUROLOGIC

Migraines / Headaches _____
Dementia _____
Parkinson Disease _____
Seizure / Tremors /Tics _____
Extremity Weakness/Numbness _____
Fatigue _____
Insomnia _____
Stroke _____
Poor Balance _____
Speech Problems _____
Neuromuscular Disease _____
ADD / ADHD _____

PSYCHOLOGIC

Depression _____
Anxiety _____
PTSD _____
Paranoia _____
Bipolar disorder _____
Schizophrenia _____
Hallucinations or Delusions _____
Suicidal Thoughts _____
Attempted Suicide _____
Uncontrolled Anger / Outbursts _____
Violent Behavior _____
History of Mental Health Crises _____

_____

History of Psychiatric Admission _____
If Yes, When and Where _____

_____

ECT or TMS _____

CARDIOVASCULAR

High Blood Pressure _____
Controlled / Uncontrolled _____
Chest Pain _____
Heart Attack _____
Heart Cath/Stents _____
Heart Murmur _____
Valve Disease _____
Heart Failure _____
Abnormal Heart Rhythm _____
POTS syndrome _____
Swelling in Extremities _____
Difficulty Breathing while lying _____
Exercise Intolerance _____
Other _____

RESPIRATORY / ENT

Shortness of Breath _____
Asthma _____
Obstructive Sleep Apnea _____
CPAP _____
Oxygen Use _____
Frequent Nose Bleeds _____
Pulmonary Hypertension _____
Chronic Bronchitis _____
Difficulty Swallowing _____
Hoarseness _____
Swollen Lymph Nodes _____
Neck Pain or Stiffness _____
Seasonal Allergies _____
Coughing or wheezing _____
Other Lung Issues _____

UROLOGY / GASTROINTESTINAL

Kidney Disease / Failure / Transplant/ Stones _____

_____

Excessive Urinating _____
Recurrent UTI's _____
Incontinence _____
Liver Disease _____
Hepatitis A, B, or C _____
Did you have treatment/when _____
GERD _____
Nausea / Vomiting _____
Diarrhea _____
Abdominal Pain _____
Other _____

_____

_____

ILLUMINATE KETAMINE CENTER

Name: _____ DOB: _____

METABOLIC / ENDOCRINE

Hypothyroid (underactive) _____
Hyperthyroidism (overactive thyroid) _____
Diabetes Type I _____ Type II _____
Insulin dependence _____
Autoimmune Disorder _____
Fibromyalgia _____
Rheumatoid Arthritis _____
Lupus _____
Hair Loss _____
Unexplained Weight Loss or Gain _____
Intolerance to Heat or Cold _____
Other _____

PAIN

Neuropathic Pain _____
Chronic Pain _____
CRPS _____
Cancer Pain _____
Other _____

MUSCULOSKELETAL

Degenerative Disc Disease _____
Cervical Neck Injury _____
Arthritis _____
Osteoporosis _____
Joint Replacements _____
History of Fractures _____
Other _____

INFECTIOUS DISEASE

HIV _____
Tuberculosis _____
Covid 19 _____
Other _____

GYN

Last period _____ Menopause yes no
Pregnancies _____ #Live Births _____
Tubal / Hysterectomy Endometriosis _____
Birth control/ HRT _____

HEMATOLOGY / ONCOLOGY

Bleeding Disorder _____
Cancer *(explain)* _____
Chemotherapy _____
Radiation _____
Other _____

SOCIAL HISTORY

Current Smoker _____ Packs per day _____
What Age Did You Start Smoking _____
Former Smoker _____ When did you quit _____
Vape or E Cig Use _____
Smokeless Tobacco _____
Other _____
Alcohol Use NONE
# of Drinks Daily _____
# of Drinks Weekly _____
History of Alcohol Abuse _____
Substance Use / Abuse *(please circle)*
Marijuana Cocaine PCP Methamphetamine
Opiates Benzos Heroin Ketamine
Other Recreational drugs _____
Last Use _____
History of IV Drug Use _____
Last Use _____
Are you Safe in Your Current Living Environment? _____
History of assault/Sexual abuse _____
If yes, at what age _____
History of violent behavior _____

ILLUMINATE KETAMINE CENTER

Name: _____ DOB: _____

PAST SURGICAL HISTORY

History of Problems with Anesthesia _____

_____

Family History of Problems with Anesthesia _____

_____

Surgery and Procedures **DATE**

_____

_____

_____

_____

_____

_____

_____

_____

Other Concerns not Listed

_____

_____

_____

_____

Patient Signature _____ **Date** _____ **Time** _____

Provider Signature _____ **Date** _____ **Time** _____