ARISE RECOVERY CENTERS

Medical History

Client Name_____Nickname_____Age_____

Name of Physician/and their specialty_____

Most recent physical examination_____Purpose_____

What is your estimate of your general health ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:

1. Hospitalization for illness or injury Y☐ N☐
2. An allergic reaction to
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals (nickel, gold, silver, _____)
   - ☐ latex
   - ☐ other_____
3. heart problems, or cardia stent within the last six months Y☐ N☐
4. history of infective endocarditis Y☐ N☐
5. artificial heart valve, repaired heart defect (PFO) Y☐ N☐
6. pacemaker or implantable defibrillator Y☐ N☐
7. artificial prosthesis (heart valve or joints) Y☐ N☐
8. rheumatic or scarlet fever Y☐ N☐
9. high or low blood pressure Y☐ N☐
10. a stroke (taking blood thinners) Y☐ N☐
11. anemia or other blood disorder Y☐ N☐
12. prolonged bleeding due to a slight cut (INR.3.5) Y☐ N☐
13. emphysema, shortness of breath, sarcoidosis Y☐ N☐
14. tuberculosis, measles, chicken pox Y☐ N☐
15. asthma Y☐ N☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) Y☐ N☐
17. kidney disease Y☐ N☐
18. liver disease Y☐ N☐
19. jaundice Y☐ N☐
20. thyroid, parathyroid disease, or calcium deficiency Y☐ N☐
21. hormone deficiency Y☐ N☐
22. high cholesterol or taking statin drugs Y☐ N☐
23. diabetes (HbA1c-___) Y☐ N☐
24. stomach or duodenal ulcer Y☐ N☐
25. digestive disorders (i.e. celiac disease, gastric reflux Y☐ N☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) Y☐ N☐
27. arthritis, rheumatoid arthritis, lupus Y☐ N☐
28. glaucoma Y☐ N☐
29. contact lenses Y☐ N☐
30. head or neck injuries Y☐ N☐
31. epilepsy, convulsion (seizures) Y☐ N☐
32. neurologic disorders, (ADD/ADHD, prison disease) Y☐ N☐
33. viral infections and cold sores Y☐ N☐
34. any lumps or swelling in the mouth Y☐ N☐
35. hives, skin rash, hay fever Y☐ N☐
36. STI/STD Y☐ N☐
37. Hepatitis (type___) Y☐ N☐
38. HIV/AIDS Y☐ N☐
39. Tumor, abnormal growth Y☐ N☐
40. Radiation therapy Y☐ N☐
41. Chemotherapy, immunosuppressive Y☐ N☐
42. Emotional problems Y☐ N☐
43. Psychiatric problems Y☐ N☐
44. Antidepressant medication Y☐ N☐
45. Alcohol/street drug use Y☐ N☐

ARE YOU:

46. Presently being treated for any other illness Y☐ N☐
47. Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) Y☐ N☐
48. Taking medication for weight management Y☐ N☐
49. Taking dietary supplements Y☐ N☐
50. Often exhausted or fatigued Y☐ N☐
51. Experiencing frequent headaches Y☐ N☐
52. A smoker, smoked previously or used smokeless tobacco Y☐ N☐
53. Considered a touchy person Y☐ N☐
54. Often unhappy or depressed Y☐ N☐
55. FEMALE – taking birth control Y☐ N☐
56. FEMALE -pregnant Y☐ N☐
57. MALE – prostate disorders Y☐ N☐

On the reverse side of this form, please describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your drug and alcohol treatment. (Please Turn Over)

List all medications and vitamins taken within the last two years	**Drug**	**Purpose**	**Drug**	**Purpose**
	If you are taking more than six medications, please document them on the reverse side of this sheet.			

(Please Turn Over)

Additional Information

Please advise us in the future of any change in your medical history or any medications you may be taking.

Client's Signature_____Date_____

Clinician's Signature_____Date_____