Lighthouse Christian Counseling Center, LLC
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MEDICAL INFORMATION SHEET

Name:		Today's date:		height		weight	
Date last seen by a physician:		Recent weight gain or loss (how much, when?)					
Date of last complete physical:		List any allergies/sensitivities to medications					
List any lab tests in the last 12 months:							

Physician(s) name(s)	(1)	Phone:	
	(2)		
	(3)		

List all current medications	Reason for taking:	Dosage and frequency	Date began:	Prescribed by:
Please describe any negative side effects or any other problems w/ meds:				

Surgeries:	Month and year of surgery:	Comments:
Hospitalizations (list reason)	Month and year:	Comments:

Medical Symptoms/conditions: (please write "C" for current symptoms, and "P" for past symptoms)					
	Fainting/Loss of consciousness		Severe head injury		Cancer
	Seizures		Meningitis/encephalitis		Heart condition
	Severe headaches		Trouble walking		Thyroid disorder
	Visual disturbances		Tingling or numbness		Jaundice or live disease
	Diseases of male/female organs		Chronic cough/lung disease		Stomach problems
	Kidney or Bladder problems		Tumor		High blood pressure
	Prostate problems		Severe PMS symptoms		Anemia or other blood disorder
	Attention Deficit Disorder		Lupus or arthritis		

HABITS

Do you exercise regularly?	**Y**	**N**	If so, how often?
Do you take vitamins?	**Y**	**N**	
Do you smoke?	**Y**	**N**	If so, how much?
Did you smoke in the past?	**Y**	**N**	How much? For how long?
Do you drink alcohol?	**Y**	**N**	Ave. # of drinks per week:
Do you use recreational drugs?	**Y**	**N**	Type and usage:
Drugs in the past?	**Y**	**N**	
Were you ever told you were drinking or using drugs too much?	**Y**	**N**	If so, when and by whom?:

Family Medical History:
Check all that apply and list the person's relationship to you

	Diabetes			Suicide or suicide attempt	
	Alcoholism			Heart disease under 55	
	Hereditary disease			Depression	
	Abnormalities at time of birth			Mental Health problems	

For Women only:

Last menses began:		Miscarriage (w/ year)	
Are your cycles regular?		Abortions (w/ year)	
Number of pregnancies:		Have you ever been on hormone replacement therapy (if so, when)?	
Number of living children:			