Atlanta Center for Adult ADHD | Medical History

Name: _____

Address: _____

Phone (W): _____(H)_____(C)_____

DOB: _____ Age: _____

(Circle One) Married Single Long Term Relationship Divorced/Separated

Children? ( ) No ( )Yes Current Ages(list) _____

Residing with you? ( )N ( ) Y If no, Where _____

Education (Check most recent degree):

( ) Graduate School ( ) College ( ) Professional or Vocational School

( ) High School ( ) Grade _____

Are You Currently Employed? ( )Y ( )N Where (if "no", Where were you last employed?)

_____ What type of work do/did you do? _____

How long have/did you work (ed) there?_____

Emergency Contact: _____

Relationship to patient:_____ _____ Ph:_____ ____

Primary care physician:_____ _____ Ph:_____ ____

Date of last physical:_____

Have you had any of the following?

Problem	No	Yes	It yes, please give age & describe condition / treatment received
Allergies			
Angina (chest pain)			
Asthma			
Cerebrovascular Accident (stroke) or TIA			
Coronary Artery Disease			
GERD (gastroesophogeal reflux)			
Hyperlipidemia			
Hypertension			
Kidney Disease			
Liver Disease			
Migraine Headaches			
Myocardial Infarction (heart attack)			
Seizure Disorder (convulsions)			

Syncope (passing out)			
Thyroid Disease			
Concussions / other head injuries			
Abnormal heart rhythm			
Other heart condition			
Development delay or learning disability?			
Surgery?			
Other overnight hospital stays?			

Have you had recent problem with the following?

Heat Intolerance ? ☐ No ☐ Yes Feeling wired / jittery (w/o having caffeine) ? ☐No ☐Yes Unintentional weight gain? ☐No ☐ Yes

Cold Intolerance ? ☐ No ☐Yes Tremor (abnormal shaking of hand / body)? ☐ No ☐Yes Unintentional weight loss? ☐No ☐ Yes

Excessive sweating? ☐ No ☐ Yes Unexplained weakness? ☐ No ☐ Yes

Other (Please describe) _____

_____

_____

_____

_____

_____

If there is a family history of any of the illnesses listed above, please put an "F" next to that illness

Have you ever been treated for substance misuse (rehab, counseling, detox)? ( ) No ( ) Yes

(Please describe when, where and for how long)

Is there a family history of anything NOT listed here? (Please Explain) _____ _____

_____

_____

Have you ever had surgery or been hospitalized? (Please Describe) _____

_____

_____

Have you or a family member ever been diagnosed with a psychiatric or mental illness? (Please describe)

_____

_____

Have you ever taken or been prescribed any medicine for psychiatric conditions besides ADHD (i.e. Depression, Anxiety, Bipolar): ( )No ( )Yes If yes, please list medications, condition treated and dates taken.

_____

_____

_____

Please list all current prescription medications and how often you take them (example: Dilantin 3x/day). DO NOT include medications you may be currently misusing (that information is needed later).

_____

_____

_____

Please list all current medicines, vitamin supplements, etc. and how often you take them

_____

Please list any allergies you have:

_____

Tobacco History

Cigarettes: Now? ( ) No ( ) Yes In the past? ( ) No ( ) Yes

How many per day on average?_____ For how many years? _____

Substance Use History

	No	Yes/Past Or Yes/Now	Route	How much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Methamphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
Stimulants (pill)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Sleep Patterns

Sleep Schedule	Weekdays	Weekends
Usual Awakening time	am/pm	am/pm
Usual bedtime (getting into bed)	am/pm	am/pm
Amount of time before falling asleep	min.	min.

Average # of hours of sleep per night: _____

Trouble falling sleep: ☐No ☐Yes

Difficulty staying asleep: ☐No ☐Yes

Frequent waking episodes at night: ☐No ☐Yes

Disrupted breathing. Gasping, or choking for air during sleep: ☐No ☐Yes

Reasons for this consultation – Please list your current concerns in order of highest priority first.

a. _____

b. _____

c. _____

d. _____

Have you ever been diagnosed with ADHD in the past? ☐Yes ☐No If yes, how old were you? _____

Who made the diagnosis? ☐Psychologist ☐Pediatrician ☐Family MD ☐Psychiatrist ☐Other_____

Which of the following do you recall being involved in making this diagnosis?

☐Clinical interview and Observation ☐Checklists by patient ☐Checklists by parents

☐Checklists by teachers ☐Psychoeducational testing ☐Computerized testing ☐Other (specify) _____

Did you ever see a psychologist for psychological and/or educational testing? ☐Yes ☐No

Please list the medications (if any) you are currently taking or have received in the past for ADHD.

Name of medication	How long & age(s) while taking	Was it effective helping with ADHD?	What side effect (if any) did you have taking this?	If stopped, why?
		Yes Somewhat No		
		Yes Somewhat No		
		Yes Somewhat No		
		Yes Somewhat No		
		Yes Somewhat No		
		Yes Somewhat No		