



# THE LAKEWOOD GROUP, LLC

## *Mental Health Services*

2237 Ridge Road • Suite 101 • Rockwall, Texas 75087-5161  
 (972) 771-3969 • Fax: (972) 771-8258  
 www.lakewoodgroup.net

**Robert F. Mehl, III, Ph.D. & Associates, LLC**  
 Robert F. Mehl, III, Ph.D.  
 H. Michael Cunningham, Ph.D.  
 Alan Cooper, Ph.D.  
 Chris L. Poulson, Psy.D.  
 Judy L. Rambur, Psy.D., RPT  
 Terri Creamer, Ph.D.  
 Joan M. Franklin, Ph.D.  
 Christine M. Gonzalez, Ph.D., LP, LSSP  
 Ashley D. Barnes, Ph.D.  
**Mary Watts Crutchfield, M.D., P.A.**  
**Cini Abraham, M.D.**

### MEDICAL HISTORY REVIEW QUESTIONNAIRE

NAME \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

QUESTIONNAIRE COMPLETED BY \_\_\_\_\_ DATE \_\_\_\_\_

**CURRENT MEDICAL CARE:** Are you or have you ever been under the care of a physician for any type of medical problem? If so, please explain.

**CHECKUP:** Approximate date of your last checkup: \_\_\_\_\_ Done for : (Circle) Illness Routine Work Insurance

Name of Doctor \_\_\_\_\_ Address \_\_\_\_\_

Included in checkup: (Circle) History Physical Blood Tests Urine Tests X-Ray EKG (cardiogram) Pap Smear

Date of your last tetanus shot: \_\_\_\_\_

**MEDICATION:** Please list all medications (prescription and non-prescription) that you currently take and dosages, if known.

**ALLERGIES:** Please list all medications you are allergic to including X-Ray dye.

**HOSPITALIZATIONS AND SURGERY:** List any and all surgeries (problem, year, location, hospital or doctor).

List any other hospitalizations (problem, year, location, hospital or doctor)

List any psychiatric treatment you have had (problem, year, location, doctor)

**WEIGHT:** Now \_\_\_\_\_ One year ago \_\_\_\_\_ Have you had a 10 lb. Weight change within the last year? \_\_\_\_\_

**ALCOHOL AND TOBACCO:** Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink alcohol? (Circle) Never, Less than one drink daily, 1-2 daily, More than 2 daily

Have you ever drunk more heavily than you do now? \_\_\_\_\_ Have you ever taken unprescribed drugs (including street drugs)? \_\_\_\_\_ If so, specify \_\_\_\_\_

		YE S	NO	<u>EXPLAIN ALL YES ANSWERS</u>
1.	Have you had any fever in the last week?			
2.	Do you have frequent headaches? If so, describe what they are like			

3.	Have you had a recent change in your vision or hearing?			
4.	Have you ever had numbness, severe muscular weakness?			
5.	Have you ever had trouble with dizziness?			
6.	Have you had seizures or tics?			
7.	Have you had unusual sensitivity to heat or cold or insensitivity?			
8.	Do you have trouble breathing, a chronic cough, or have you coughed up blood?			
9.	Do you have chest pains, high blood pressure, or heart problems?			
10.	Do you have abdominal pains, change in bowel habits, or rectal bleeding?			
11.	Do you have difficulty or pain in urination, or blood in urine?			
12.	Have you had blackout spells?			
13.	Do you have trouble with walking or balance?			
14.	Do you have back pain or other back problems?			
15.	Do you have arthritis?			
16.	Have you had frequent ear infections?			
17.	Have you had frequent sore throats?			

FOR WOMEN: (If you are uncomfortable answering any of these questions, you may respond later in private with your physician.)

Are you having periods? Yes \_\_\_ No \_\_\_ Date of last normal menstrual period: \_\_\_\_\_

Menses: (Check appropriate blank) Normal \_\_\_ Heavy \_\_\_ Irregular \_\_\_

Please explain \_\_\_\_\_

Possibility of current pregnancy. (Check one) Yes \_\_\_ No \_\_\_

Pregnancies: Number \_\_\_ Miscarriages \_\_\_ Abortions \_\_\_ Complications \_\_\_\_\_

History of venereal disease (herpes, gonorrhea, syphilis) \_\_\_\_\_

Date of last pap smear \_\_\_\_\_ Birth Control Pills \_\_\_\_\_

Recent change in sexual functioning \_\_\_\_\_

FOR MEN: (If you are uncomfortable answering any of these questions, you may respond later in private with your physician.)

Age of puberty \_\_\_\_\_ History of venereal disease (herpes, gonorrhea, syphilis, non-specific discharge) \_\_\_\_\_

Recent change in sexual functioning \_\_\_\_\_

ADOLESCENT AND CHILDREN---Inoculation dates:

DPT or TD \_\_\_\_\_ basic series \_\_\_\_\_ boosters \_\_\_\_\_

Polio \_\_\_\_\_ basic series \_\_\_\_\_ boosters \_\_\_\_\_

Measles \_\_\_\_\_ Mumps \_\_\_\_\_

Rubella \_\_\_\_\_ Most recent Tine Test \_\_\_\_\_