BRIGHT LIFE MEDICAL & PSYCHIATRIC SERVICES P.C.

Full Name: _____

Date of birth: _____

Mailing Address: _____

_____

(Home Phone)_____ (Work Phone) _____

(Cell Phone)_____ (Email) _____

I prefer for the medical office to contact me during our business hours at:

❑ Home Phone ❑Work Phone ❑ Cell Phone ❑ Email ❑ Specify: _____

My Primary Care Physicians:

_____

_____

Other Health Care Providers:

_____

_____

If I am unable to make decisions because of severe illness, this is name and contact information for the person I prefer to make emergency decisions for me:

_____

_____

_____

❑ Partner/Spouse ❑ Friend
❑ Adult Child ❑ Legal Guardian
❑ Parent ❑ _____

Past Medical History and Current Medical Problems (include the date/year of diagnosis)

Previous surgeries or injuries

Family medical history
(indicate the person's relationship to you and the diagnosis)

Caffeine? ☐ None [ ] Estimated 8-ounce caffeinated beverage per day ___

Tobacco? ☐ None [ ] Smoked cigarettes from age ____ to ____. ____ packs per day.
Check if you've used the following: [ ] Cigars [ ] Chewing Tobacco

Alcohol ? ☐ None [ ] Estimated drinks per week ____
Check if you've had the following alcohol complications: ☐ Black-outs ☐ Legal Problems ☐ Withdrawal Symptoms

Drugs? ☐ None [ ] Type(s) and history of use _____

Please list current medications, including supplements or vitamins:

Please list allergies or intolerances of medications, latex, dyes, foods, or other:

Describe your typical physical activities/exercise:

Describe your typical daily diet:

Do you have any concerns about violence or abuse in your current environments? ◯ Yes ◯ No
Have you been a victim of previous violence or abuse? ◯ Yes ◯ No

Signature: _____ Date: _____