Gary Elkins, Ph.D., ABPP

Health History Update

Date: _____

Name:_____ Date of Birth:_____

Home Address: _____ Age: _____

City: _____

Zip Code: _____

Telephone Number: Home:_____Work:_____

Cell:_____

Marital Status: Married ____ Single _____ Other _____

Employer or School Name: _____

Insurance Plan Name and Policy Number (check all that apply):
Scott and White ____ Medicare ____ BCBS ____ Self-Pay ____
Subscriber ID: _____

What is the name of your physician? _____

Please list any prescription, herbal or over-the-counter medication(s) you are taking and the reason for taking each:

_____

_____

_____

Are you allergic to any medication(s) or material(s)? If so, please list: _____

_____

Please explain the primary concern you are experiencing/the reason for referral:

_____

_____

_____

Have you had any of the following diseases or medical problems? (*circle all that apply*)

Alcohol Abuse
Anxiety
Arthritis
Asthma
Attention Deficit Disorder/ADHD
Cancer/Chemotherapy
Depression
Diabetes
Drug Abuse
Eating Disorder
Emphysema
Epilepsy
Fainting Spells
Fears
Flashbacks
Hallucinations
Heart Attack
Hearing Problems
Hemophilia
Hepatitis
Heart Surgery
High Blood Pressure
HIV+/AIDS
Hospitalized for any reason
Hot Flashes
Kidney Problems
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Pacemaker
Panic Disorder
Radiation Treatment
Rheumatic/Scarlet Fever
Seizures
Sexual/Physical Abuse
Sinus Problems
Stroke
Thyroid Problem
Tuberculosis (TB)
Ulcers

*List any other medical problems: _____

Do you smoke? _____ If yes, how much and how long? _____

Do you drink alcohol? _____ If yes, how much/often? _____

Do you have any concerns about your sleep? _____

How is your appetite? _____

How is your energy level? _____

Do you have any history of legal problems? _____

Have you ever seen a psychologist, psychiatrist, or mental health provider in the past?
Yes ____ No ____ If yes, why? _____

The information that I have given is correct and I understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____