AMG Ketamine & Wellness Center

Patient Medical History

Date

General Information	
Patient Name	
Age	
Date of Birth	
Phone	
Secondary Phone	
Email	
Emergency Contact	
Emergency Contact Phone	
Height	
Weight	
Occupation	
How did you learn about our Center?	☐ Dr. _____ ☐ Facebook ☐ Friend or relative ☐ Radio ☐ Internet search ☐ Publication _____ ☐ YouTube ☐ Other _____
What condition are we seeing you for?	

Current Medications / **Please list all medications, supplements, or herbs taken currently.**

Medication	Dose	Frequency

Current Medications / Please list all medications, supplements, or herbs taken currently.		

Allergies

Previous Surgeries / Please provide the date of surgery, if known.	
Surgery	**Date**

Prior Anesthesia Complications

Family History of Anesthesia Complications

Substance Use

Substance	How Much?	How Long?	Last Use?
Tobacco			
Alcohol			
Marijuana			
Cocaine			
Other			

Medical History / Please check all that apply.

☐	Asthma	☐	Acid Reflux
☐	COPD/Emphysema/Bronchitis	☐	Cirrhosis/Liver Problems
☐	Sleep Apnea	☐	Diabetes
☐	Shortness of Breath	☐	Seizures
☐	Coronary Artery Disease	☐	Stroke or TIA
☐	Prior Heart Attack	☐	Brain Aneurysm
☐	Chest Pain	☐	Blurred Vision/Vision Problems
☐	Congestive Heart Failure (CHF)	☐	Hypothyroid
☐	Dysrhytmias (irregular heart rhythms)	☐	Hyperthyroid
☐	Pacemaker/ICD	☐	Headache/Migraine
☐	High Blood Pressure	☐	Urinary Problems
☐	High Cholesterol	☐	Kidney Problems
☐	Heart Murmur/Valve Issue	☐	Anemia or Abnormal Bleeding
☐	Cancer	☐	Nausea/Vomiting
☐	Fatigue	☐	Weight Loss/Gain

Medical History / **Please check all that apply.**			
☐	Hot Flashes	☐	Back Pain
☐	Joint Pain	☐	Insomnia
☐	Mood Change	☐	Anxiety/Nervousness
☐	Depression	☐	Memory Loss
☐	Bipolar Disease	☐	Schizophrenia
☐	Attempted Suicide	☐	Chronic Pain

Please list other medical problems that are not included above

Current Psychiatric Diagnosis (if applicable)

Psychiatric Medical Hospitalizations & Related Diagnosis

Pregnant or possibility of pregnancy?

Last menstrual period

Family medical history / **Please include significant medical problems and relationship to you**

For Patients With Depression

I agree to seek immediate help from a suicide hotline, licensed mental health provider, and/or hospital emergency department in the event that my symptoms worsen or I experience an increase in suicidal thoughts, feelings, or urges.

Signature | Printed Name | Date