Iberville Parish Substance Abuse Center
Medical History

Last Name	First Name	Date	Client Number

Do you have any allergies to medicine, food, drugs or inhalants? ☐ Yes ☐ No

If yes, list: _____

Medications taken within the last 14 days:

Pregnant ☐ N/A ☐ Yes ☐ No	Birth Control Pills ☐ N/A ☐ Yes ☐ No	Cigarette Smoker ☐ Yes ☐ No

Indicate by a (✔) if you have or had any of the listed below health problems

☐ Heart disease	☐ Kidney disease	☐ Cancer
☐ Chest pain	☐ Lung disease	☐ Bone/Joint disorder
☐ Irregular heartbeat	☐ Shortness of breath	☐ Chronic headache
☐ High blood pressure	☐ Emphysema	☐ Chronic pain
☐ Low blood pressure	☐ Asthma	☐ Mental illness
☐ Stroke	☐ TB or exposure	☐ Alcoholism
☐ Blood disease	☐ Gastrointestinal disorder	☐ Drug addiction
☐ Immunological disorder	☐ Ulcers	☐ Seizures
☐ Liver disease	☐ Thyroid gland disease	☐ Delirium tremens
☐ Hepatitis A B C	☐ Weight change	☐ Depression
☐ Jaundice	☐ Insomnia	☐ Surgeries
☐ Recurring infections	☐ Diabetes	☐ HIV/AIDS

Explanation, if needed, of above noted problems:

Date of Last Physical Examination	Family Doctor/Clinic	Address/Location

Have you ever been treated for mental health problems? ☐ Yes ☐ No

Name of Facility/Agency	Diagnosis	Medication(s) Prescribed	Year(s) of Service

Client Signature	Date
Staff Signature	Date

(For Medical Personnel Only)

Reviewed by (If other than MD):	Date	Deferred to

Disposition:

Dr. Luke Lee	Date