Lumos Psychiatric Services
Past History Form (Adults 18-64yrs)

Patient's Name:_____ MR:_____ Date:_____/_____/_____

Instructions: The following questions are part of your previous history which is very important for your evaluation and to best come up with a treatment plan for you. Some of the questions you will find are more sensitive than others and you might feel somewhat uncomfortable with them. We want to emphasize that it's very important for you to be as honest as possible with all the questions so your psychiatrist can best help you.

Confidentiality Disclosure: *We assure you that all this information is completely confidential and will not be shared with anyone unless you provide the consent.* We thank you for trusting us with your care, we will do everything we can to best help you with your situation.

Past Medical History:

Have you ever been diagnosed with any medical conditions by a physician? Yes No

If yes, which of the following conditions have you been diagnosed with? (Mark all that apply with an X)

Cardiovascular: ___Angina Pectoris ___Arterial Hypertension ___Atrial Fibrillation ___Cardiac Arrhythmia ___Carotid Artery Disease ___Cerebrovascular Accident/Stroke ___Congestive Heart Failure ___Coronary Artery Disease ___Deep Vein Thrombosis ___Heart Murmur ___Hypotension ___Myocardial Infarction ___Obesity ___Transient Ischemic Attack ___Heart Valvular Disease ___Congenital Heart Disease.

Dermatological: ___Acne ___Albinism ___Alopecia ___Atopic Dermatitis ___Eczema ___Hidradenitis Suppurativa ___Hyperhidrosis ___Keloids ___Psoriasis ___Rosacea ___Seborrheic Dermatitis ___Urticaria ___Vitiligo.

Endocrinological: ___Adrenal Mass ___Cushing's Syndrome ___Diabetes Mellitus ___Graves' Disease ___Growth Hormone Deficiency ___Hashimoto's Thyroiditis ___Hypercholesterolemia ___Hyperlipidemia ___Hyperthyroidism ___Hypertriglyceridemia ___Hypoglycemia ___Hypothyroidism ___Insulin Resistance ___Metabolic Syndrome ___Pre-Diabetes ___Testosterone Deficiency ___Thyroid Nodules ___Vitamin B12 Deficiency ___Vitamin D Deficiency.

Gastrointestinal: ___Abdominal Hernia ___Acid Reflux ___Appendicitis ___Barrett's Esophagus ___Celiac Disease ___Chronic Constipation ___Cirrhosis ___Crohn's Disease ___Diverticulosis ___Dysphagia ___Fatty Liver Disease ___Gallstones ___Gastritis ___Gastroparesis ___GERD Gastroesophageal Reflux Disease ___Gluten Intolerance ___H. Pylori Infection ___Hemorrhoids ___Hepatitis ___Hiatal Hernia ___Inflammatory Bowel Disease ___Irritable Bowel Syndrome ___Lactose Intolerance ___Liver Transplantation ___Pancreatitis ___Peptic Ulcer Disease ___Rectal Prolapse ___Splenomegaly ___Ulcerative Colitis.

Gynecological: ___Amenorrhea ___Cervical Dysplasia ___Chronic Pelvic Pain ___Dyspareunia ___Endometriosis ___Galactorrhea ___Female Infertility ___Menopause ___Menorrhagia ___Miscarriage ___Ovarian Cyst ___Polycystic Ovarian Syndrome ___Pelvic Inflammatory Disease ___Premenstrual Dysphoric Mood Disorder ___Uterine Fibroids ___Uterine Prolapse ___Vaginismus.

Head, Ears, Eyes, Nose, Throat: ___Allergic Rhinitis ___Astigmatism ___Bell's Palsy ___Blindness ___Benign Positional Paroxismal Vertigo ___Cataracts ___Chronic Sinusitis ___Glaucoma ___Hearing Loss ___Macular Degeneration ___Meniére's Disease ___Myopia ___Retinal Detachment ___Retinopathy ___Strabismus ___Temporomandibular Joint Syndrome ___Tinitus ___Vertigo.

Hematological: ___Anemia ___Blood Transfusion History ___Hemochromatosis ___Hemophilia ___Iron Deficiency ___MTHFR Deficiency ___Multiple Myeloma ___Polycythemia Vera ___Porphyria ___Sickle Cell Disease ___Thalassemias ___Von Willebrand Disease.

Infectious Diseases: ___Cellulitis ___Chickenpox ___Chlamydia (STD) ___COVID-19 ___Dengue Fever ___Gonorrhea (STD) ___Hepatitis B or C ___Herpes (STD) ___HIV ___HPV (Human Papillomavirus) ___Lyme Disease ___Meningitis ___Rheumatic Fever ___Shingles ___Syphilis (STD) ___Tuberculosis.

Musculoskeletal: ___Arthritis ___Bone Fractures ___Bursitis ___Bunions ___Carpal Tunnel Syndrome ___Costochondritis ___Chronic Back Pain ___Chronic Fatigue Syndrome ___Chronic Hip Pains ___Chronic Knee Pains ___Chronic Neck Pain ___Chronic Shoulder Pains ___Degenerative Spinal Disk Disease ___Herniated Vertebral Disks ___Muscular Dystrophy ___Osteomyelitis ___Osteopenia ___Osteoporosis ___Plantar Fasciitis ___Radiculopathy ___Scoliosis ___Spondylitis ___Tendonitis ___Trauma.

Neurological: ___Amyotrophic Lateral Sclerosis ___ Cerebral Aneurysm ___Cerebral Palsy ___Complex Regional Pain Syndrome ___Concussion ___Dementia ___Dyslexia ___Dystonia ___Encephalopathy ___Epilepsy/Seizures ___Essential Tremor ___Guillain Barré Syndrome ___Head Trauma ___Hemiparesis ___Huntington's Disease ___Intracranial Bleeding ___Migraines/Headaches ___Mild Cognitive Impairment ___Multiple Sclerosis ___Myasthenia Gravis ___Narcolepsy ___Nerve Damage ___Parkinson's Disease ___Parkinsonism ___Peripheral Neuropathy ___Post Concussion Syndrome ___Pseudobulbar Affect ___Pseudoseizures ___Pseudotumor Cerebri ___Restless Legs Syndrome ___Sciatica Pains ___Spinal Cord Injury ___Spinal Stenosis ___Tardive Dyskinesia ___Tourette's Disorder ___Traumatic Brain Injury ___Trigeminal Neuralgia ___White Matter Disease.

Renal & Urological: ___Chronic Kidney Disease ___End-Stage Renal Disease (ESRD) ___Kidney Cyst ___Kidney Transplantation ___Nephrolithiasis ___Nephrotic Syndrome ___Polycystic Kidney Disease ___Renal Failure ___Renal Insufficiency ___Benign Prostatic Hyperplasia ___Bladder Prolapse ___Chronic Cystitis ___Delayed Ejaculation ___Erectile Dysfunction ___Hyperactive Bladder ___Incontinence ___Male Infertility ___Overactive Bladder ___Premature Ejaculation ___Urinary Retention ___Varicocele.

Respiratory: ___Asthma ___Bronchitis ___Chronic Obstructive Pulmonary Disease ___Cystic Fibrosis ___Obstructive Sleep Apnea ___Pneumonia ___Pulmonary Cysts ___Pulmonary Embolism ___Pulmonary Fibrosis ___Pulmonary Hypertension ___Pulmonary Nodules ___Sarcoidosis.

Rheumatological: ___Ankylosing Spondylitis ___Ehlers-Danlos Syndrome ___Fibromyalgia ___Giant Cell Arteritis ___Gout ___Juvenile Idiopathic Arthritis ___Mixed Connective Tissue Disease ___Osteoarthritis ___Psoriatic Arthritis ___Rheumatoid Arthritis ___Scleroderma ___Sjögren's Syndrome ___Systemic Lupus Erythematosus.

Have you ever been diagnosed with any form of cancer by a physician? Yes No
If yes, when was it diagnosed and what type of cancer was it?
_____
_____

Have you ever had any seizures, convulsions or been diagnosed with Epilepsy? Yes No
If yes, since when and what kind of seizures?
_____
When was the last time you had a seizure? (if applies)
_____

Have you ever had any trauma or accident to your head? Yes No
If yes, when did it happen? _____ Did you lose consciousness? Yes No
Did you remain with any particular deficits or disabilities from the head trauma and if so, which?
_____
_____

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Are you allergic to any medications or over-the-counter supplements? Yes No
If yes, name all items you are allergic to and what reaction you had to it.

_____ _____
_____ _____
_____ _____
_____ _____

Have you ever been pregnant in your life? (This only applies to females) N/A Yes No
If yes, how many pregnancies have you had? _____ How many natural births?_____ Cesarean sections?_____
Have any of them resulted in abortion? Yes No ____ Spontaneous, ____ Elective, ____ Ectopic Pregnancy
Do you have regular menses? Yes No Do you use oral contraceptives or intrauterine device? Yes No
If so, which? _____ Have you gone through the process of menopause? Yes No

Past Surgical History:

Have you ever been operated on or had any surgeries? Yes No
If yes, please mark which of the following operations have you had performed? (Mark all that apply).

Cardio/Thoracic: ___Chest Tube Placement/Removal ___Heart Defibrillator Placement ___Heart Pacemaker Placement ___Heart Transplant ___Heart Valve Replacement ___Heart Valvular Repair Surgery ___Lung Lumpectomy ___Lung Resection ___Lung Transplant ___Open Heart Surgery ___Ribs Reconstruction Surgery.

Dermatological: ___Hemangioma Removal ___Keloid Removal ___Lipoma Resection ___Skin Abscess Drainage ___Skin Cancer Resection ___Skin Cyst Removal ___Skin Graft.

Gastrointestinal: ___Adrenalectomy ___Anal Fissure Repair ___Appendectomy ___Bariatric Surgery ___Cholecystectomy ___Colon Partial Resection ___Colon Total Resection ___Colostomy Bag Placement/Removal Surgery ___Diverticular Resection Surgery ___Exploratory Surgery ___Fistula Repair ___Gastrostomy Tube Placement/Removal ___Hemorrhoid Repair Surgery ___Hernia Repair ___Liver Resection ___Liver Transplantation ___Pancreatic Resection Surgery ___Pyloric Stenosis Repair ___Rectal Prolapse Repair Surgery ___Small Bowel Resection ___Splenectomy ___Whipple Procedure.

Head, Eyes, Ears, Nose, Throat: ___Adenoidectomy ___Cataract Surgery ___Cochlear Implant Surgery ___Deviated Nasal Septum Repair ___Ear Reconstructive Surgery ___Ear Tube Placement/Removal ___Eye Surgery ___Intraocular Lens Replacement ___LASIK Surgery ___Maxillary Sinus Surgery ___Sinus Surgery ___Strabismus Repair Surgery ___Thyroidectomy ___Tonsillectomy ___Tympanic Replacement Surgery.

Neurological: ___Brain Aneurysm Repair ___Brain Tumor Resection ___CFS Shunt Placement/Removal ___Craniotomy ___Deep Brain Stimulator ___Nerve Block ___Spinal Tap Procedure ___Spine Surgery ___Vagal Nerve Stimulation Implantation.

OBGYN: ___Cervical Polyp Resection ___Cesarean Section ___Dilation and Curettage Procedure ___Ectopic Pregnancy Resection ___Endometriosis Resection Surgery ___Hysterectomy ___LEEP Procedure ___Oophorectomy ___Salpingectomy ___Sterilization (Tubal Ligation Surgery) ___Uterine Ablation ___Uterine Polyp Resection ___Uterine Prolapse Repair Surgery.

Oncology: ___Biopsy (Organ:_____) ___Tumor/Cancer Resection Surgery (Organ:_____) ___MedPort Placement/Removal ___Radiotherapy Treatment.

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Orthopedics: ___ACL Reconstruction Surgery ___Amputation Repair Surgery ___Ankle Replacement Surgery ___Arthroscopy ___Bunions Removal ___Carpal Tunnel Surgery ___Elbow Replacement Surgery ___Fracture Repair ___Hand Surgery ___Herniated Disks Repair ___Hip Replacement Surgery ___Knee Replacement Surgery ___Ligament Repair ___Meniscus Repair Surgery ___Pinched Nerve Spinal Repair ___Plantar Fasciitis Repair ___Rotator Cuff Surgery ___Shoulder Replacement Surgery ___Spinal Cord Stimulator ___Spinal Fusion ___Tarsal Tunnel Surgery ___Tendon Repair ___Trigger Finger Repair.

Plastic Surgery: ___Abdominoplasty ___Breast Augmentation Surgery ___Breast Lift Surgery ___Breast Lumpectomy ___Breast Mastectomy ___Breast Reconstruction Surgery ___Breast Reduction Surgery ___Facelift Surgery ___Facial Reconstruction Surgery ___Gender Reassignment Bottom Surgery ___Gender Reassignment Top Surgery ___Gluteal Implant Surgery ___Gluteal Lift Surgery ___Liposuction Procedure ___Male Mastectomy ___Pectoral Implants Surgery ___Rhinoplasty ___Testicular Implant Surgery.

Renal/Urological: ___Dialysis Shunt Placement/Removal ___Kidney Cystectomy ___Kidney Resection ___Kidney Transplantation ___Bladder Cystoscopy ___Bladder Repositioning Surgery ___Circumcision ___Cryptorchidism Repair ___Lithotripsy Procedure ___Penile Surgery ___Prostate Resection ___Prostate Surgery ___Renal Calculus Removal Surgery ___Testicular Resection ___Testicular Torsion Repair ___Ureter Repair Surgery ___Urethra Repair Surgery ___Varicocele Surgery ___Vasectomy ___Vesicoureteral Reflux Repair.

Vascular Surgery: ___Cardiac Ablation ___Aneurysm Repair Surgery ___Bifemoral Bypass Surgery ___Carotid Artery Repair ___Carotid Endarterectomy/Stent Placement ___Catheterization Procedure ___Coronary Artery Bypass Graft Surgery ___Coronary Stent Placement ___Inferior Vena Cava Filter ___Lower Aorta Stent Placement ___Lower Extremity Vein Ablation ___Lower Extremity Vein Ablation ___Lower Extremity Vein Bypass ___Varices Removal (Lower Extremities).

Family History:

Have any of your family members been diagnosed with a mental health or psychiatric disorder, such as Depression, Anxiety, Schizophrenia/Psychosis, Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Obsessive-Compulsive Disorder, Panic Disorder, Eating Disorder? Yes No

If yes, please name which family member and which condition.

___ Mother: _____ Alive Deceased
___ Father: _____ Alive Deceased
___ Brothers: _____ Alive Deceased
___ Sisters: _____ Alive Deceased
___ Sons/Daughters: _____ Alive Deceased
___ Maternal Grandparents: _____ Alive Deceased
___ Paternal Grandparents: _____ Alive Deceased
___ Maternal Aunts/Uncles: _____ Alive Deceased
___ Paternal Aunts/Uncles: _____ Alive Deceased
___ Cousins: _____ Alive Deceased

Have any of your family members ever tried to commit suicide or take their own lives? Yes No

If yes, Who? _____ When? _____ Which method they used? _____

Did you whiteness the attempt? Yes No Was the suicide completed? Yes No

Have any of your family members had problems with the use of alcohol or illegal drugs? Yes No

If yes, Who? _____ Which Substance? _____

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Have any of your family members had memory problems or been diagnosed with Dementia? Yes No
If yes, Who? _____ At what age?_____ Which type? ___Alzheimer's
___ Vascular ___ Lewy-Body ___ Fronto-Temporal

Social History:

Where are you originally from? _____ Since what year have you lived in Florida? _____
Where do you currently live? ___ House, ___ Apartment, ___ Trailer/Mobil Home, ___ Assisted Living Facility/Home
___ Homeless // In which city or county do you currently live? _____
Who do you live with at the moment? ___Alone, ___ Spouse, ___Children, ___Parents, ___Roommate, ___Partner
Name who lives with you, include mascots: _____
_____

Relationship status: ___ Single, ___ Married, ___ Living with Partner, ___ Divorced, ___Widowed, ___Never Married
If married or living with a partner, name your spouse/partner, and how long have you been married/ together?
_____
If divorced or widowed, how long was the relationship, how long ago did you divorce or became widowed?
_____
Do you have any children? Yes No How many? _____ Please list their first names, ages and sexes:
_____
Who constitutes your biggest support group? _____

Sexual Orientation: ___ Heterosexual, ___ Homosexual, ___ Bisexual, ___ Pansexual, ___ Asexual, ___Demisexual
Which sex where you biologically born as? ___ Male, ___ Female
With which gender do you identify? ___Male, ___Female / ___Transgender (Male to Female/Female to Male)
___Non-Binary, ___ Other:_____

Current working status?
___ Work Full-time ___ Work Part-time ___ Unemployed ___ Disabled ___ Stay At Home Parent ___ Retired
If working, where do you work, how long have you been working there and what do you do at your work?
_____
If un-employed/retired, where was your last job, how long did you work there and how long have you been un-employed/retired? _____
If disabled, since when have you been disabled? _____ (Year)/ Disabled due to Illness: ___Physical ___Mental
Economically: ___Self-Dependent ___Dependent on: ___Spouse ___Parents ___Family ___Government Assistance

Level of Education:
What is the highest level of education you have achieved?
___ Grade #___ / ___ High School / ___ GED / ___ Associate's Degree / ___ Technical Degree /
___ Bachelor's Degree / ___ Master's Degree / ___ Doctor's Degree
Are you currently studying? ___ Yes ___ No / ___ Part-time Studying ___ Full-time Studying
What school are you currently attending? _____

If completed any College Degree and higher, what was your studies concentration? (List all for Associate, Technical, Bachelor, Master, Doctor, Post-Doctorate studies if they apply.)
Associate's: _____ Technical: _____
Bachelor's: _____ Master's: _____
Doctor's: _____ Post-Doctorate's: _____

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Religion:

Do you have any specific religion or spiritual belief system? ___Yes ___No / Which of the following?
___Atheist ___Agnostic ___Spiritual ___Catholic ___Christian ___Protestant ___Baptist ___Judaism ___Islam
___Evangelist ___Buddhism ___Hinduism ___Pentecostal ___Mormon ___Adventist ___Satanism ___Paganism
___Jehovah's Witness ___Methodist ___Lutheran ___Other: _____
If you do practice a religion, how important is your religion to you?
___ Not important ___ Somewhat Important ____ Very Important ___ Extremely Important
Do you consider your religion or spiritual belief system and fellow members of your religion a good support system? Yes No

Legal History:

Have you ever had a legal problem such as being arrested, accused, or convicted for a crime? Yes No
If yes, for which crime and when? (list all if more than one.) _____
_____
Do you own or possess any kind of firearm (gun, pistol, revolver, machine gun, rifle)? Yes No
If yes, do you have a permit for said firearm? ___Yes ___No / Concealed Carrier Permit? ___Yes ___No
Which type and how many firearms do you own? _____Handgun/s _____Shotgun/s _____Rifle/s
Where do you store your firearm/s usually? (Be specific) _____
_____

Military History:

Have you ever been a part of the military service? ___Yes ___No
If yes, what is your current status in the military? ___ Active ___ Inactive ___ Discharged ___ Retired
What was/is your military branch? ___Army ___Navy ___Marines ___Air Force ___Coast Guard ___Space Force
Have you had deployments? ___Yes ___No / If yes, where? _____
If discharged, which kind of discharge was it? ___ Honorably ___ Dishonorably ___ Medically
What years did you serve? _____ What was the reason for discharge? _____
_____

Abuse/Trauma History:

Have you ever experienced a traumatic event that really affected you? Yes No
Please state what was that event: _____
Have you ever been a victim of any kind of abuse? Yes No
Which type of abuse have you experienced? (Mark all that apply)
___ Psychological/Emotional ___ Physical/Aggression ___ Domestic Violence ___ Sexual Assault/Rape
Who was the perpetrator of the abuse?_____ When did it happen?_____
_____

Patient's Signature: _____ Clinician Signature:_____

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