ENHANCED WELLNESS *of* NEW MEXICO
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MEDICAL HISTORY QUESTIONNAIRE *for* KETAMINE IV THERAPY

PERSONAL HISTORY

Patient name: .... Date: ....

Date of birth: .... Age: .... Occupation: ....

Home address: ....

City: .... State: .... Zip: ....

Home phone: .... Cell phone: .... Work phone: ....

e-Mail address: .... May we contact you via email? ☐ Yes ☐ No

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EMERGENCY CONTACT INFORMATION:

Name: .... Relationship: ....

Home phone: .... Cell phone: .... Work phone: ....

Primary Care physician's name: .... Phone: ....

Address: ....

City: .... State: .... Zip: ....

Any known allergies? ....

How did you hear about ketamine infusions?

Referring Provider: .... Phone: (   )

Primary Care Provider: Phone: (   )

Mental Health Provider: Phone: (   )

CURRENT MEDICATIONS | SUPPLEMENTS

NAME OF MED	DOSE

NAME OF MED	DOSE

I am currently compliant with all medications prescribed by my mental health provider

☐ Yes ☐ No If no, please explain: ....

PAST MEDICAL HISTORY

Please check appropriate box below and provide date of onset for any past or current conditions you have.

P Past Condition   C Current Condition

NEUROLOGICAL/MOOD DISORDERS:

- P C Depression Date of onset: __/__/__
- P C Anxiety Date of onset: __/__/__
- P C PTSD Date of onset: __/__/__
- P C Insomnia Date of onset: __/__/__
- P C Schizophrenia Date of onset: __/__/__
- P C Hallucinations Date of onset: __/__/__
- P C ADD/ADHD Date of onset: __/__/__
- P C Suicidal Date of onset: __/__/__
- P C History of mental health crises Date of onset: __/__/__
- P C Seizures Date of onset: __/__/__
- P C Stroke Date of onset: __/__/__
- P C ADD/ADHD Date of onset: __/__/__
- P C Neuromuscular disease Date of onset: __/__/__
- P C History of psychiatric admissions Date of onset: __/__/__
- P C Other Date of onset: __/__/__

METABOLIC/ENDOCRINE:

- P C Hypothyroid (underactive) Date of onset: __/__/__
- P C Hyperthyroid (overactive) Date of onset: __/__/__
- P C Other Date of onset: __/__/__

RESPIRATORY:

- P C Shortness of breath Date of onset: __/__/__
- P C Asthma Date of onset: __/__/__
- P C Obstructive Sleep Apnea Date of onset: __/__/__
- P C Pulmonary Hypertension Date of onset: __/__/__
- P C Other lung disorders Date of onset: __/__/__

URINARY/GASTROINTESTINAL:

- P C Kidney disease Date of onset: __/__/__
- P C Liver disease Date of onset: __/__/__
- P C Other Date of onset: __/__/__

PAST MEDICAL HISTORY *continued*

Please check appropriate box below and provide date of onset for any past or current conditions you have.

P Past Condition C Current Condition

CARDIOVASCULAR:

- **P** **C** High blood pressure
  ☐ Controlled ☐ Uncontrolled
  Date of onset: __/__/__
- **P** **C** Chest pain Date of onset: __/__/__
- **P** **C** Heart murmur Date of onset: __/__/__
- **P** **C** Heart attack Date of onset: __/__/__
- **P** **C** Valve disease Date of onset: __/__/__
- **P** **C** Heart failure Date of onset: __/__/__
- **P** **C** Abnormal heart rhythm
  Date of onset: __/__/__
- **P** **C** Bleeiding disorder
  Date of onset: __/__/__
- **P** **C** Other Date of onset: __/__/__

PAIN ISSUES:

- **P** **C** Acute pain Date of onset: __/__/__
- **P** **C** Chronic pain Date of onset: __/__/__
- **P** **C** Fibromyalgia Date of onset: __/__/__
- **P** **C** Other Date of onset: __/__/__

INFECTIOUS:

- **P** **C** HIV Date of onset: __/__/__
- **P** **C** Tuberculosis Date of onset: __/__/__
- **P** **C** Hepatitis Date of onset: __/__/__
- **P** **C** Other Date of onset: __/__/__

HEMATOLOGY/ONCOLOGY:

- **P** **C** Bleeding disorder
  Date of onset: __/__/__
- **P** **C** Cancer Date of onset: __/__/__
- **P** **C** Other Date of onset: __/__/__

OTHER:

- **P** **C** Substance abuse (please check):
  - ☐ Marijuana Date of onset: __/__/__
  - ☐ Cocaine Date of onset: __/__/__
  - ☐ Methamphetamine Date of onset: __/__/__
  - ☐ Heroin Date of onset: __/__/__
  - ☐ Ketamine Date of onset: __/__/__
- **P** **C** Other recreational drugs
  Date of onset: __/__/__
  Last use: __/__/__
- **P** **C** History of assault
  Date of onset: __/__/__
- **P** **C** History of violent behavior
  Date of onset: __/__/__
- **P** **C** Other Date of onset: __/__/__
- **P** **C** Past surgeries Date of onset: __/__/__

Patient signature: .... Date: ....