

NAME _____ BIRTHDATE _____ AGE _____ TODAY'S DATE _____

REASON FOR VISIT TODAY? _____

MEDICAL HISTORY

ALLERGIES OR DRUG REACTIONS: _____

MEDICATIONS (PLEASE LIST ALL MEDICATIONS INCLUDING ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS & SUPPLEMENTS TAKEN IN THE PAST 3 MONTHS):

NOW? _____

IN THE PAST THREE MONTHS? _____

DOU YOU CONSUME GRAPEFRUIT/GRAPEFRUIT JUICE Y___ / N___ (INTEREACTS WITH MEDS)

HABITS:

	CURRENT USE	PAST USE
TOBACCO	_____	_____
ALCOHOL	_____	_____
“RECREATIONAL DRUGS”	_____	_____
CAFFEINE	_____	_____

ILLNESS: (PAST AND PRESENT)

CARDIAC? Y___ N___ THYROID? Y___ N___ GLAUCOMA? Y___ N___
SEIZURES? Y___ N___ DIABETES? Y___ N___ CHOLESTEROL PROBLEMS? Y___ N___
SURGERIES? _____
ACCIDENTS/HEAD INJURIES? _____
OTHER MEDICAL PROBLEMS? _____

FEMALES ONLY: ARE YOU PREGNANT? Y___ N___ PLANNING TO GET PREGNANT? Y___ N___

NUMBER OF PREGNANCIES _____ MISCARRIAGES _____ ABORTIONS _____

PSYCHIATRIC HISTORY

PREVIOUS PSYCHIATRISTS/THERAPISTS: WHEN? _____

MEDICATIONS PRESCRIBED IN THE PAST? _____

PSYCHIATRIC HOSPITALIZATIONS: WHEN? _____ WHY? _____

WHEN? _____ WHY? _____

FAMILY HISTORY

PSYCHIATRIC PROBLEMS (IN YOUR FAMILY): _____

SUICIDE ATTEMPTS IN YOUR FAMILY? _____

SEIZURES _____ THYROID DISEASE _____

DRUG PROBLEMS? _____ ALCOHOL ABUSE PROBLEMS? _____