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? _____

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? _____

Please be aware all medicines may have the potential to cause problems in pregnancy or with the developing fetus.